

**United States Department of the Interior**  
National Park Service

# National Register of Historic Places Registration Form

This form is for use in nominating or requesting determinations for individual properties and districts. See instructions in National Register Bulletin, *How to Complete the National Register of Historic Places Registration Form*. If any item does not apply to the property being documented, enter "N/A" for "not applicable." For functions, architectural classification, materials, and areas of significance, enter only categories and subcategories from the instructions.

## 1. Name of Property

Historic name: Livingston Memorial Hospital

Other names/site number: \_\_\_\_\_

Name of related multiple property listing:

N/A

(Enter "N/A" if property is not part of a multiple property listing)

## 2. Location

Street & number: 504 S. 13<sup>th</sup> Street

City or town: Livingston State: Montana MT County: Park

Not For Publication: NA

Vicinity: NA

## 3. State/Federal Agency Certification

As the designated authority under the National Historic Preservation Act, as amended,

I hereby certify that this x nomination    request for determination of eligibility meets the documentation standards for registering properties in the National Register of Historic Places and meets the procedural and professional requirements set forth in 36 CFR Part 60.

In my opinion, the property x meets    does not meet the National Register Criteria. I recommend that this property be considered significant at the following level(s) of significance:

   national    statewide x local

Applicable National Register Criteria:

x A    B    C    D

\_\_\_\_\_  
Signature of certifying official/Title:

\_\_\_\_\_  
Date

\_\_\_\_\_  
State or Federal agency/bureau or Tribal Government

In my opinion, the property    meets    does not meet the National Register criteria.

\_\_\_\_\_  
Signature of commenting official:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title :

\_\_\_\_\_  
State or Federal agency/bureau  
or Tribal Government

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#### 4. National Park Service Certification

I hereby certify that this property is:

- ☐ entered in the National Register  
☐ determined eligible for the National Register  
☐ determined not eligible for the National Register  
☐ removed from the National Register  
☐ other (explain:) \_\_\_\_\_

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Signature of the Keeper

Date of Action

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#### 5. Classification

##### Ownership of Property

(Check as many boxes as apply.)

- Private: ☒
- Public – Local ☐
- Public – State ☐
- Public – Federal ☐

##### Category of Property

(Check only **one** box.)

- Building(s) ☒
- District ☐
- Site ☐
- Structure ☐
- Object ☐

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**Number of Resources within Property**

(Do not include previously listed resources in the count)

Contributing	Noncontributing	
<u>1</u>	<u>3</u>	buildings
<u>          </u>	<u>          </u>	sites
<u>          </u>	<u>          </u>	structures
<u>          </u>	<u>          </u>	objects
<u>1</u>	<u>3</u>	Total

Number of contributing resources previously listed in the National Register N/A

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**6. Function or Use**

**Historic Functions**

(Enter categories from instructions.)

Health Care – Hospital

**Current Functions**

(Enter categories from instructions.)

Vacant/Not in Use

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## 7. Description

### Architectural Classification

(Enter categories from instructions.)

Modern Movement – International Style with Prairie Style influences

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**Materials:** (enter categories from instructions.)

Principal exterior materials of the property: Brick

### Narrative Description

(Describe the historic and current physical appearance and condition of the property. Describe contributing and noncontributing resources if applicable. Begin with a **summary paragraph** that briefly describes the general characteristics of the property, such as its location, type, style, method of construction, setting, size, and significant features. Indicate whether the property has historic integrity.)

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#### Summary Paragraph

Livingston Memorial Hospital is a one-story, multi-wing, flat-roofed building of hollow masonry construction. Completed in 1955, the original design exhibits many character defining features of Mid-Century Modern architecture. The former hospital rests on a conventional reinforced concrete strip foundation with stem walls. It encompasses approximately 39,500 square feet, with 11,450 square feet in the basement and 28,050 on the elevated first story. On the first floor, approximately 25,520 square feet is original, while the remainder is divided between two additions from c. 1987-1989. The larger addition is situated at the north corner of the building, between the hospital's original administrative and surgical wings. Because it primarily added space for emergency and critical services, it is referred to in this document as the "ER Addition." The smaller (about 500-square-foot) addition created four patient rooms in the courtyard between the hospital's rear wings. It is referred to as the "Rooms Addition." Livingston HealthCare vacated the building in October 2015 upon completion of their new \$43.5 million medical complex on the other side of town.

Exterior walls of the former hospital are built with hollow structural brick and stand between 13' and 15' tall. They are clad in buff-colored face brick with vertical scoring. A single soldier course of brick runs just above the visible concrete foundation. Two stacked half-bat bricks are used along this course at building corners, entrances and other original openings (i.e. louver vents). The greyish mortar has a concave point. Most original entrances and some isolated windows feature rowlock brick lintels. The

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lintels extend past the opening and “drip” down into a short course of three rowlock bricks. In this way, the lintels evoke traditional label molding (sometimes referred to as dripstone or hood molding). Other isolated windows lack lintels, but have projecting limestone sills. Horizontal window bands, a hallmark of Mid-Century Modernism, surround much of the original building. Each band is 5’ 5” tall and framed with protruding limestone trim. Red brick, which provides a dramatic contrast with the buff wall face, fills the space between the deeply recessed windows in each band. Original windows were typical three-part metal sashes with an operable awning light. Most were replaced with elongated casement windows during the c. 1987-1989 remodeling project, but there are intact examples in the administrative and maternity wings.

The original curtain wall main entrance is situated in the end of the building’s northeast administrative wing. A second primary entrance was added on the northwest elevation when the ER Addition was constructed in c. 1987-1989. In general, most openings in the original building retain their dimensions but hold replacement doors and windows. The flat roof is covered in rubber membrane. It features a deep overhanging eave that projects 2’ 6” over most original building elevations. The roof fascia is a two piece built up wood assembly with metal flashing. Most of the building’s trim (fascia boards, soffit panels, doors, etc.) is painted a light yellow-beige that compliments the buff brick. The wood framing of the original window wall entrance, in contrast, is painted chestnut brown.

The first floor of the original building is elevated about 3’ above grade and covers approximately 25,520 square feet. Its complex shape is composed of five wings arranged around a central rectangular core, with each wing corresponding to a hospital function. The original administrative wing (41’ x 79’) extends to the northeast, the surgical wing (48’ x 84’) to the northwest, the pediatric wing (44’ x 80’) to southeast, and the maternity wing (44’ x 110’) and nursing wing (44’ x 129’) to the southwest. The two rear wings (maternity and nursing) were originally attached to the main building via short hyphens with angled northwest elevations. Inside the hospital, rooms generally have 9’ ceilings. The main exception is the original operating rooms at the end of the surgical wing which have 10’ 6” ceilings. A T-shaped basement is situated under the administrative wing and hospital core. The boiler room, cafeteria and laundry services were located in the basement. Crawl spaces are found under the pediatric, nursing and maternity wings, while the area under the surgical wing is unexcavated. There is also a basement under the ER Addition.

Designed by the Cushing & Terrell (now CTA), an architectural firm based in Billings, Montana, the former hospital exhibits many character defining features of Mid-Century Modern architecture, including clean lines with a strong horizontal orientation, minimal ornament, continuous windows bands, and a curtainwall main entrance. Other original elements, including the deeply overhanging eaves, diagonally-oriented entrance canopy (non-extant), and the detached, downward sloping roof over the surgical wing, move the design into a later period of more expressive modernism referred to as Exaggerated Modern or Googie style. The c. 1987-1989 alterations to the building, also designed by CTA, are sympathetic to the original design but display subtle differences. For instance, there is no overhanging eave on the ER Addition, and horizontal banding on both additions is framed with rowlock brick instead of limestone.

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## **Narrative Description**

### **SETTING & LOCATION**

Livingston Memorial Hospital stands on a full city block (Block 29, Park Addition) near the southwest edge of Livingston, the administrative seat of Park County, Montana. This community of approximately 7,400 is situated at the great eastern bend of the Yellowstone River. At Livingston, the Yellowstone exits the mountain-lined Paradise Valley and turns toward the Great Plains and its eventual confluence with the

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Missouri River. Livingston is surrounded by mountain landscapes on nearly every side, with the Gallatin Range to the southwest, the Absaroka Range to the southwest, the Bridger Range to the northwest and the Crazy Mountains to the northeast. One of Montana's most important east-west transportation routes follows the Yellowstone River to Livingston, before heading over the Bozeman pass to reach the Gallatin Valley and the headwaters of the Missouri. This route was used by Native Americans, Capt. William Clark on his return trip from the Pacific in 1806, the Northern Pacific Railroad, U.S. Highway 10, and now, Interstate 90. A secondary north-south route (U.S. 89) travels north through Paradise Valley, passes through Livingston, and then continues north through the Shields Valley on its way to Great Falls, Montana. Historically, Livingston and Park County were associated with the Northern Pacific Railroad, tourism in Yellowstone National Park, ranching, mining, timber and the arts.

In 1882, the Northern Pacific Railroad platted Livingston in alignment with its newly-completed main line and the Yellowstone River. These linear features run parallel about one-half mile from each other in a southwest to northeast direction. As such, Livingston's street grid is offset at a 45° angle from the cardinal directions. Livingston's original plat was followed closely by four additions: the Riverside Addition to the southeast, the Minnesota Addition to the northeast, the Palace Addition to the northwest, and the Park Addition to the southwest. Livingston Memorial Hospital stands on Block 29 of the Park Addition, at the very southwest corner of Livingston's historic street grid. Livingston's commercial district is situated about one mile to the northwest. The hospital site is bounded by S. 13<sup>th</sup> Street to northwest, Crawford Street to the northeast, S. 14<sup>th</sup> Street to the southwest, and Cambridge Street to the southeast.

When the hospital was constructed in the early 1950s, the area to the north (toward downtown) was already filling with residential development. There was also a linear strip along the railroad line / highway corridor that travels west of the hospital on its route to Yellowstone National Park. The area to the south, in contrast, remained undeveloped until the mid-1950s and 1960s. Several factors drove postwar development on the southwest edge of town: selection of the hospital site (1947), platting of the Werner Addition and street paving (1953), designation of Geyser Street as a through street (1955), and construction of Interstate 90 about one-half mile south of the hospital in c. 1962. As a result, much of the residential and commercial development south and west of Livingston Memorial is characterized by a Mid-Century Modern or Late Modern design aesthetic. The hospital also spurred construction of other medical facilities in its immediate vicinity. A clinic was built in c. 1962 across Cambridge Street, while a multi-wing retirement home was erected to the west of the hospital in c. 1971. The Modern style clinic, which was recently converted into apartment units, is an especially nice architectural complement to Livingston Memorial Hospital. In essence, the hospital's immediate surroundings further solidify its historical and architectural significance rather than compromising its physical integrity.

### **HOSPITAL SITE (BLOCK 29, PARK ADDITION)**

The hospital block covers approximately three acres and sits at an elevation of between 4,520 and 4,526 feet. There is a slight rise near the middle of the block and a general downward eastern slope as the landscape approaches the Yellowstone River. However, neither of these topographic features had a significant impact on the hospital's original design. The hospital is in the north half of the block, with primary entrances off S. 13<sup>th</sup> Street and Crawford Street. There are three additional buildings on the block: the c. 2004 Mental Health Building, and two small frame utility structures that date from c. 1975. [Photos 21, 24 and 25]. Of these buildings, which are considered non-contributing resources, only the Mental Health Building is truly intrusive. This one-story, gable-roofed structure stands off the northwest corner of the hospital and is not in keeping with its Mid-Century Modern aesthetic. Fortunately, it is set back about 20' feet from the hospital's original maternity wing and about 30' from the surgical wing. The smaller frame buildings are situated off the northeast elevation of the hospital and at the southwest corner

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of the block, respectively. Both are simple, one-story rectilinear structures that are clearly subservient to the larger hospital building. Prior to the hospital's abandonment, there were modular units attached to the maternity and nursing wings. These were recently removed, but concrete footings are still extant at the southwest end of the nursing wing.

The hospital site also includes several important features related to circulation. Historically, visitors and staff at Livingston Memorial parked on the street and walked to the main entrance. Ambulances accessed the hospital via a concrete ramp and service drive off Crawford Street, with the original emergency room being in the "ell" between the administrative and surgery wings. By the early 1970s, there was also a semi-circular drive for pick-up / drop-off to the southeast of the main entrance and a small parking lot at the northeast corner of the block. These areas were eventually paved, with one of the small utility buildings constructed in the center of the curved drive. Over the next few decades, two additional circulation features were added to the site: a gravel parking lot at the south corner of the block and a concrete helicopter pad off the southeast end of the hospital [Photos 21 and 23]. At the pedestrian scale, there are paved sidewalks along S. 13<sup>th</sup> and Crawford Streets, but not S. 14<sup>th</sup> and Cambridge Streets. The following paved walks access the building: a walk from the gravel parking lot to the nursing wing entrance, a walk from the pediatric wing entrance to the helipad and paved drive, a walk from S. 13<sup>th</sup> Street to the original main entrance, a ramp from the paved parking lot to the Crawford Street entrance, and a walk from the paved parking lot to a basement-level entrance at the "ell" between the surgery and maternity wings.

A final landscape component that contributes significantly to the hospital site is vegetation. Grass lawn covers much of the block to the south of the hospital. Cottonwoods were planted along Cambridge Street and S. 14<sup>th</sup> Street shortly after the hospital's construction. Today, the mature trees create a lovely windbreak, although several trees were removed in mid-2000s [Photo 21]. More recently, trees were planted at the west and north corners of the block. Ornamental trees also dot the hospital grounds. A cluster of trees anchored by a tall, mature spruce is situated just southeast of the original main entrance—in the center of the curved drive. The north corner of the hospital site is also nicely landscaped [Photo 19]. Shrubbery (especially juniper) is used to great effect in keeping with the building's Mid-Century Modern aesthetic. There are also a few lower trees (both broadleaf and pine) in this area and a small lawn. Trees and shrubs also adorn the courtyard between the building's two rear wings [Photo 13]. Lastly, a lone crabapple tree stands off the southeast elevation of the nursing wing [Photo 22].

### **LIVINGSTON MEMORIAL HOSPITAL: Detailed Exterior Description**

The original portion of Livingston Memorial Hospital is composed of a central core and five wings named for their original function: administrative, surgical, pediatric, maternity, and nursing. There are also two additions constructed during a multi-phase remodeling project in c. 1987-1989. These are the ER Addition at the north corner of the building and the Rooms Addition in the rear courtyard between the nursing and maternity wings. Each component (the core, five original wings, and two additions) are described in detail below. A key with each component superimposed on a current first-story floor plan is also included with this application for further clarity.

#### Hospital Core

The hospital core is situated at the center of the hospital with the various wings and additions radiating off in spokes. It is approximately 100' long and 44' to 48' wide, with a northeast-southwest orientation. It is flanked on this orientation by the surgical wing to the northwest and the pediatric wing to the southeast. The administrative wing stretches out to the northeast, while the nursing and maternity wings are attached to the rear (southwest) elevation of the hospital core. The ER Addition fills much of the space between the original surgical and administrative wings at the north corner of the building, while the Rooms

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Additions is in the rear courtyard. Because there are so many wings, the hospital core had only two original exterior elevations: a northeast elevation that runs between the administrative and pediatric wings and a southwest elevation in the hospital's rear courtyard. The original rear (southwest) elevation of the hospital core was removed to make way for the c. 1987 Rooms Addition. The northeast elevation, however, is still extant.

The northeast elevation of the hospital core is about 36' long. It runs perpendicular to the administrative wing at its northwest end and is flush with the pediatric wing at its southeast end. The division between the hospital core and the pediatric wing is based on interior function and not exterior appearance. Because this elevation presents as a continuous wall face, it is described below with the pediatric wing. Similarly, the non-extant rear (southwest) elevation is better associated with the back of the hospital. It is described with the Rooms Addition.

Administrative Wing (Northeast Wing)

This wing originally had three elevations (northeast, northwest and southeast), with hospital's main entrance situated in the northeast end. The northwest elevation, however, is almost completely covered by the c. 1987 ER Addition. On the interior, the original floor plan consisted of a long corridor lined with administrative offices. The hospital's main waiting area / lobby was situated in the northeast corner of the wing (near the entrance), while the emergency room was at the northwest corner (near the junction with the surgical wing).

The northeast elevation of the administrative wing is 41' wide and includes the hospital's original main entrance [Photo 1]. There is also a lower 6'-wide bump-out on the southeast end of this elevation. The bump-out, which shelters stairs to the basement, is flush with main wall face, but has its own flat roof with overhanging eaves. The original curtain wall main entrance dominates the northwest side of this elevation. It has been modified, but still retains its original dimensions (18' wide x 8' tall), wood frame, and most of its glass paneling. The curtain wall is comprised of six 3'-wide vertical columns. The four interior columns contain three stacked panels. Originally, these held twelve glass panels, but the bottom row of glass was replaced with solid wood paneling. The two end columns hold a door surmounted by a glass panel. The northwest door is solid wood, while its companion has a rectangular upper light. Door hinges and closers appear to be original, while the doors themselves are either replacement units or heavily modified. (Historic photographs show solid wood doors with kick plates).

A stylish, diagonally-oriented, flat canopy once protected the walk leading to the main entrance. It had a trapezoid shape and projected about 20' from the northeast corner of the administrative wing. It seems likely the canopy was removed in c. 1987 to make way of the surgical wing addition. A low, brick trapezoidal planter at the north end of the entrance was also removed at this time. The hospital's original signage—10" individual aluminum letters that read "LIVINGSTON MEMORIAL HOSITAL"—was attached to the brick wall face west of the main entrance. The signage was probably removed when Livingston Memorial Hospital changed its name to Livingston HealthCare in 2001. Finally, there is an electrical meter on the south side of this elevation. It is enclosed by a low screen with two short brick end walls and batten wood fence.

The southeast elevation of the administrative wing is 79' long [Photos 2-4]. The short, flat-roofed bump-out visible at the northeast end of the wing extends 23' along this elevation. An entrance containing an original wood door with a metal louver vent is situated at the northeast end of the bump-out. The entrance has a rowlock brick lintel. An HVAC box with a metal exhaust tank and stack is situated near the south end of the bump-out. There is a large (10' 6"-wide) window opening in the main wall face above the bump-out. It has a rowlock brick lintel and a limestone sill. According to architectural plans, this opening originally held triple two-light casement windows. The opening is currently filled with a large, stationary light and a panel of batten wood siding.



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A limestone-framed window band extends along the remainder of the southeast elevation. The window band is situated about 1' under the overhanging eave. It is 5' 5" tall and approximately 40' long with five recessed window openings divided by four red brick panels. Moving from northeast to southwest, these openings have the following widths: 8' 4", 8' 4", 5' 1", 3' 5", and 5' 1". The 8' 4" openings originally held double three-part metal windows (two tall lights over a short awning light), the 5' 1" openings held single four-part metal windows (three tall lights over a short awning light) and the 3' 5" opening held a single three-part metal window. A few original sashes in this window band are partially intact. This includes the windows in both 8' 4" openings (although three of the taller lights were modified for air-conditioning) and the single window in the 3' 5" opening (the tall lights in this window are currently painted over). The west opening is now filled with batten paneling, while the final opening is covered by an enclosed frame box that extends from grade to the overhanging eave. There is full-height, 6'-wide recess at the southwest end of this elevation where the administrative wing meets the hospital core. The recess, which extends into the building about 8', is currently covered by stacked doors of batten siding.

As discussed above, the northwest elevation of the administrative wing is mostly covered by the c. 1987 ER Addition. Architectural plans and historic photographs reveal that it was 75' long and bisected by a protruding, brick chimney (non-extant). The chimney was flanked by large 10' 6" window openings with rowlock brick lintels and limestone sills. Each held triple three-part windows (two tall lights over a short awning light). There was also a single three-part window just southwest of the chimney. The hospital's original emergency entrance was situated at the southwest end of this elevation (near the junction with surgical wing). The entrance held wood swinging doors and was reached by a concrete ramp that ran along the northeast elevation of the surgical wing. A 20' long, detached, flat canopy provided protection to the emergency ramp.

Surgical Wing (Northwest Wing)

The original surgical wing was composed of three elevations (northeast, northwest and southwest), but the northeast elevation is now mostly obscured by the c. 1987 surgical wing addition. The surgical wing has a complex roof plan compared to the hospital's other wings. At about 42' from the northwest end, the roof breaks into two sections. The typical flat roof with a 2' 6" overhanging eave continues back to the hospital core, while the roof over the end of the wing is a detached, downward sloping structure with a significantly smaller (1' 6") eave overhang. The roof break indicates an important interior function (operating rooms) and provides a rare stylistic flourish.

Architectural drawings and historic photographs reveal the original design of the largely obscured northeast elevation. The wall face was dominated by a characteristic limestone-framed window band that started at the southwest end and extended almost 60' feet. The seven recessed openings within the band had the following widths (moving from southwest to northeast): 12' 5", 4' 1", 3' 5", 3' 5", 4' 1", 4' 1", and 4' 1". The wide opening at the southwest end, which provided light to a mechanical room, held a trio of three-part metal windows (two tall lights above a short awning light). With one exception, the remaining openings held a single three-part metal frame window. The final opening (second from the northeast end) was filled with a louvered vent. There was also a concrete ramp along this elevation that provide access to the hospital's original emergency entrance at the southwest end of the administrative wing. Today, only about 30' of this elevation's northeast end remain exposed, with the rest being covered by the c. 1987 ER Addition.

The 48'-wide northwest end of the surgical wing is the original hospital's only symmetrical elevation [Photo 5]. Two massive (12' x 4') windows pour natural light into the original operating rooms. They flank a smaller, lower window that lights the surgery scrub-in and sterilization station situated between the operating rooms. Each of these openings has a projecting limestone sill, while the central opening also has a rowlock brick lintel. Originally, the two large openings held directional glass block, but this was

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removed and replaced with three large, stationary lights. The central window held a single row of four lights (possibly two casement windows). It now holds a row of three stationary lights.

The southwest elevation of the surgical wing extends 69' from its northwest end to its junction with the maternity wing [Photo 6]. On its northwest end, this elevation is characterized by the detached, downward sloping roof that crowns the operating rooms. There is a 12' x 4' opening at the southeast end of this distinctive "operating" section. It provides light to the hospital's original delivery room. Here, too, the original directional glass block was replaced with three large stationary lights. A window band is found in the more typical southeast section of this elevation. This band contains three openings before continuing along the angled wall of the hyphen that connects the maternity wing to the hospital core. The 5'-wide central opening, which lights the original labor room, is flanked by 4'-wide openings. All three openings are currently covered with batten wood siding. Two basement windows and a concrete stairwell with a basement-level entrance are situated below the window band. The entrance, which is not included in architectural plans, is protected by a tubular metal safety rail. A metal handrail attached to the building helps pedestrians negotiate the concrete stairs, which lead to a solid wood door.

Pediatric Wing (Southeast Wing)

The pediatric wing of the hospital is composed of three elevations: the 129'-foot long northeast elevation, the 44'-wide southeast end, and the 64'-long southwest elevation. There is a small (7' wide x 3' 7" deep) setback at the end the northeast elevation. It contains an entrance that accesses an interior flight of stairs to the elevated first story. The roofline and overhanging eave follow the setback, providing further visual interest. The rear (southwest) elevation of the pediatric wing was originally about 16' longer, but the recess at its junction with the nursing wing was infilled during the c. 1987-1989 remodeling project. (NOTE: The west 36' of the northeast elevation is functionally part of the hospital core, but because the elevation presents a continuous wall face it is described here.)

The northeast elevation is characterized by a long limestone-framed window band flanked by entrances [Photos 4 and 7]. The entrance at the northwest (interior) end of the elevation provides access to interior split-level stairs. As such, it serves as a primary access point to the basement and the hospital core. The entrance has a rowlock brick lintel and contains a wood door with an upper light and a kick plate. This door appears to be original to the building, although a modern lever handle with a passcode panel was recently installed. The door in the setback entrance at the end of the pediatric wing also appears to be original. It is a wood door with an upper light, a lower wood panel, a kick plate and an original handset pull. This entrance lead to an interior stairway that accesses the elevated first story. Like its counterpart at the other end of the elevation, this entrance has a rowlock brick lintel.

The window band on the northeast elevation is approximately 105' long and contains eleven openings. Moving from southeast to northwest, there are six 5' 1"-wide openings followed by a 1' 9"-wide opening, a 5' 1"-wide opening and three 1' 9"-wide openings. At the first slender (1' 9"-wide) window, this elevation transitions on the interior from the pediatric wing to the hospital core. In general, the wide openings hold side-by-side metal casement windows, while the slimmer openings hold a single casement window. The only exception is the second window from the southeast end, which is currently covered with batten wood siding. According to architectural plans, the original windows were either four-part metal sashes (three tall lights above a short awning light) or two-part metal sashes (one tall light above a short awning light). The window pattern indicates the original interior floor plan, with patient rooms at the end of the wing and storage, restrooms and utility space near the hospital core.

The 44'-wide southeast end of the pediatric wing is relatively simple [Photos 8, 9 and 23]. It has a 3' 7"-wide setback on its northeast end that accommodates a northeast-facing entrance. A characteristic window band begins about 13' from the southwest end. This window band turns the corner and continues down the entire rear (southwest) elevation of the pediatric wing [Photos 9, 10 and 22]. Two massive (12' 6"-

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wide) openings at the southwest corner of the pediatric wing once provided ample light to the interior playroom. The openings originally held a trio of three-part metal windows (two tall lights above a short awning light), but are currently covered with batten wood siding. Before the hyphen connecting the nursing wing to the hospital core was infilled, the window band on the rear (southwest) elevation of the pediatric wing held five 5' 1"-wide openings, but the two interior (northwest) openings were lost during that renovation. Of the three remain openings, two hold side-by-side metal casement windows, while the interior (northwest) is currently covered with batten wood siding.

Maternity Wing (North Rear Wing)

The maternity wing is connected to the hospital core by a 10'-long hyphen. On its interior (southeast) elevation, the hyphen had a 7' 4" rectangular setback, while the exterior (northwest) elevation is a setback, diagonally-oriented wall. The setbacks were protected by the main roof of the maternity wing, which did not follow the shape of the hyphen. The interior (southeast) elevation of the hyphen was swallowed by the "Rooms Addition" built in the rear courtyard in c. 1987, while the angled exterior (northwest) elevation is exposed but heavily modified [Photo 6]. According to architectural plans, window bands from the surgical wing and the original rear elevation of the hospital core (now covered by the c. 1987 Rooms Addition) turned their respective corners and continued along through the maternity wing hyphen. The hyphen's interior (southeast) elevation had a 5' 1"-wide window, while the angled exterior (northwest) elevation had an 8' 6"-wide window that provided light to the maternity waiting room. Today, the angled elevation is dominated by an elevated entrance, although the limestone frame and red brick of the window band is still visible. The entrance, which holds a wide wood door with an upper light, was built out to directionally align with the hospital (and not the angled wall face of the hyphen).

In contrast to the heavily modified hyphen, the main body of the maternity wing has a relatively straightforward design with three elevations: the 44'-wide southwest end, and the 93'-long side (northwest and southeast) elevations. There is also a projection on the end of the wing that houses an interior stair leading to the elevated first story. It is 7' deep and 20' wide and offset to the southeast. The roof and overhanging eave follow the shape of the projection, creating visual interest. The maternity wing is also the only part at the hospital that retains most of its original metal windows.

An approximately 84'-long, limestone-framed window band defines the northwest elevation of the maternity wing [Photos 11-12]. It contains eight openings with the following widths (moving from northeast to southwest): 8' 4", 5' 1", 8' 4", 5' 1", 1' 9", 5' 1", 5' 1" and 5' 1". As usual, window widths provide visual cues to the original interior floor plan. The three northwest windows indicate the nursery, with a central exam room flanked by large bassinet rooms. Moving southwest, there was a nurses' station, restroom, utility room, and two patient rooms. On this elevation, all but one opening contains an original metal window. The widest openings (8' 4") hold a pair of three-part metal windows (two tall lights over a short awning light), while the medium openings (5' 1") hold a single four-part window (three tall lights over a short awning light) and the slender openings (1' 9") hold a single two-part window (one tall light over a short awning light). The sole exception is a 5' 1"-wide opening near the northeast end of the window band, which is currently filled with batten wood siding.

The southeast elevation also has a long limestone-framed window band [Photos 13-15]. Here, however, about 18' of the elevation was absorbed by the c. 1987 Rooms Addition. This resulted in the loss of a single 5' 1"-wide window at the northeast end of the window band. The band now has eight openings (moving northeast to southwest): an 8' 4"-wide window, three 1' 9"-wide windows, two 5' 1"-wide windows, a 1' 9"-wide window and a 5' 1"-wide window. All but one of these openings holds an original metal window that matches the configuration found in the northwest elevation. The sole exception is the second window from the southwest. Originally, this opening was 5' 1" wide, but its northeast two-thirds

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are now infilled with brick. The slender opening that remains currently holds an elongated stationary light.

The 44'-wide southwest end of the maternity wing is dominated by an offset, enclosed stairway that provides access to the elevated first story [Photos 12, 13 and 17]. At 20' wide and 7' deep, the stairway has two entrances. The original entrance is situated at grade in the stairway's southeast-facing wall. It contains what appears to be an original door (a wood unit with an upper light and a kick plate) and is supported by a rowlock brick lintel. A modern lever handle and passcode panel were recently added to the door. The other entrance, which is on the southwest-facing wall of the stairway, was added at a later date. It is elevated above grade (at the first story level) and likely provided access to a series of three modular units that were once attached to the end of the maternity wing. Today, the door (a solid wood unit with a small square light) floats above grade without access stairs.

Nursing Wing (South Rear Wing)

Just like the maternity wing, the nursing wing was originally attached to the hospital core by a 10'-long hyphen. Both its southeast elevation and its angled northwest elevation held 5' 1"-wide windows. The window openings in the hyphens were situated in widow bands that wrapped around from the rear elevation of the hospital core and the southwest elevation of the pediatric wing, respectively. However, the nursing wing hyphen was erased in its entirety by the c. 1987 Rooms Addition. This remodeling project expanded the hospital core about 25' into the rear courtyard between the nursing and maternity wings, and also infilled the exterior (southeast) recess of the nursing wing hyphen. As such, the nursing wing presents three solid elevations: a 129'-long southeast elevation, a 44'-wide southwest end, and an approximately 104'-long northwest elevation. There is also a setback entrance at the end of the southeast elevation. At approximately 7' x 7', the setback houses an entrance that provides access to an interior stairway. The roof and overhanging eave follow the shape of the setback.

The long window band that runs along the interior (northwest) elevation originally framed eleven openings, with a single 1' 9"-wide window flanked by six 5' 1"-wide windows to the southwest and four to the northeast [Photos 13, 15 and 16]. The ten 5' 1"-wide held four-part metal windows (three tall lights over a short awning light), while the slender window near the center held a two-part metal window (one tall light over a short awning light). The window band on this elevation was significantly shortened with the c. 1987 Rooms Addition. Today, it contains nine openings. All but the slender opening at the northwest end are approximately 5'-wide and hold side-by-side casement windows. The slender opening holds a stationary pane. As the current configuration does not exactly match the original architectural drawings, it seems the fenestration pattern on this elevation was altered slightly. This is particularly true near the center of the elevation, where a nursing station and utility room were converted into patient rooms.

The long limestone-framed window band on the southeast elevation originally held twelve openings in the following pattern (moving from northeast to southwest): four 5' 1"-wide windows, three 1' 9"-wide windows, two 5' 1"-wide windows, two 1' 9"-wide windows and a single 5' 1"-wide window [Photos 9, 10, 17, 22 and 23]. This fenestration pattern has been retained with one exception: the second opening from the northwest is now infilled with red brick. According to architectural plans, the wider (5' 1") openings held four-part metal windows (three tall lights above a short awning light) and the slender (1' 9") openings held two-part metal windows (one tall light above a short awning light). Today, the wider openings have side-by-side casement windows, while the slender openings have single casement windows. Finally, there is side-by-side casement window in the infilled space at the end northeast end of this elevation.

The setback entrance at the end of the southeast elevation provides access to an interior stairway [Photos 17]. It contains an original wood door with a rectangular upper light, a lower wood panel and a metal kick

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plate. A modern lever handle with a passcode panel replaces the original handle. The southwest end of the nursing wing was originally a solid brick wall [Photos 13, 16 and 17]. However, a wide opening was cut into the center of the wall to provide access to a modular unit that was once attached to the nursing wing. The modular unit was removed after the hospital was vacated, and this elevated opening is now covered with plywood.

ER Addition, c. 1987 (North Corner)

Constructed in the late 1980s, the ER Addition is situated at the north corner of the building. It fills much of the space between the original administrative and surgical wings. Like the original hospital building, the ER Addition is constructed with buff-colored brick laid in a common bond. It has a flat roof with no eave and is slightly taller than the original hospital building. A subtle brick stringcourse (a soldier course capped by a rowlock course) runs a few feet below the roofline, which is defined by a soldier course of brick. The ER Addition has two elevations: a shorter (approximately 40'-long) northeast elevation and a longer (about 75') northwest elevation. The central 30' of this elevation projects about 5' out from the main wall face, adding a measure of visual interest. This elevation also has an open canopy structure that projects about 15' from the main wall face. The canopy protects a concrete ramp that provides access to the hospital's recessed emergency entrance.

The northeast elevation of the ER Addition consists of two service bays [Photo 18]. The bays are recessed into the wall face under the Addition's brick stringcourse. A perpendicular brick wall divides the bays and acts as a pilaster for the overhanging roof. The southeast bay is wider than its counterpart and recessed further into the building. It has a slanted concrete loading dock that terminates in a short flight of stairs at its wider northwest end. The southeast half of the recessed wall is currently covered in batten wood siding. The northwest half is dominated by an exterior door to a freight elevator that moved between the loading dock and a storage room in basement of the ER Addition. The shorter northwest service bay contains two grade-level entrances. There is a solid metal walk-in door to the southeast and an overhead garage door with two oval lights to the northwest. The walk-in door, which accesses a stair to the basement, has a rowlock brick lintel. This elevation abuts the administrative wing of the original hospital. The roof of the addition was built two or three feet over the original building. It is also interesting to note the northwest elevation of the administrative wing was used as a wall for the recessed service bay. The rowlock brick lintel of the northernmost window opening on that elevation is still visible, although the window is now infilled with brick.

The long northwest elevation of the ER Addition is defined by three planes that step back from the primary entrance at its southwest end: the canopy, the projecting central section, and the bisected main wall face [Photos 19-20]. A flat-roofed canopy projects out over the concrete ramp leading up to the entrance. Two square brick columns support the canopy just under the brick stringcourse. A tubular metal railing guides pedestrians to the entrance, with the concrete ramp widening at the end of the canopy. The entrance, which abuts the original surgical wing, is recessed about 20' behind the front of the canopy on the main wall face. It is only about half as wide as the canopy and is of metal curtain wall construction. The entrance is composed of double glass doors and a sidelight, which are all capped by an individual transom light. To the northeast of the entrance, the wall returns to brick. The second plane of this elevation projects about 5' from the main wall face. It begins just under the canopy and runs for about 30' before stepping back again to the elevation's primary plane.

A horizontal band of red brick runs along much of the northwest elevation, terminating just northeast of the entrance. The decorative band evokes, but does not replicate, the distinctive window bands that surround much of the original building. The main difference is that there are no windows in this band (although there is a louver vent in the central projecting plane). A second important distinction is that this band is framed with a projecting course of rowlock brick and not limestone.

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Rooms Addition, c. 1987 (Rear Courtyard)

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This small (approximately 25' x 45'), rectangular, brick addition extended the hospital core into the interior courtyard between the maternity and nursing wings. It added four patient rooms and gave the hospital core a second parallel corridor. The original rear elevation of the hospital core was removed to make way for this expansion. A window band ran across this entire elevation and turned into the courtyard, eventually terminating in the hyphens that connected the nursing and maternity wings to the hospital core. Moving from northwest to southeast, this window band contained one 8' 4"-wide window and five 5' 1"-wide windows. The large window provided light to the original service kitchen, while the smaller windows indicated patient rooms.

On the exterior, the Rooms Addition consists of a single, symmetrical, southwest-facing elevation that is approximately 45' wide [Photo 15]. It is bisected by a full-height, 14' x 6' brick projection associated with the hospital's mechanical systems. A large louver vent is centered in the southwest wall of the projection. Window bands, similar in design to those found on the original building, flank the mechanical projection. Each band contains two openings that hold side-by-side casement windows. These bands meet up with the original window bands on the interior elevations of the maternity and nursing wings. The main difference is that the window bands on the Rooms Addition are framed with projecting rowlock brick instead of limestone. In this way, they are similar to the horizontal band on the ER Addition, which was built during the same multi-phase remodeling project (c. 1987-1989). The Rooms Addition has a flat roof with an overhanging eave that follows the shape of the wall face.

### **LIVINGSTON MEMORIAL HOSPITAL: Interior Description**

Expectedly, the interior of Livingston Memorial Hospital has undergone several remodeling efforts. In general, all equipment was removed after the hospital was vacated in 2015. Much of the interior has also been selectively demolished. This included the removal of some partitions, wall and ceiling finishes, and ceiling insulation. According to a preliminary architectural report being prepared by NE45 Architecture:

The wall finishes are primarily lathe and plaster and some gypsum wall board, which are generally in poor condition...The interior walls are a mix of steel studs and 2X wood framing. The majority of the walls are 2X wood construction and vary in condition...The floor finishes are a mix of broadloom carpet and marmoleum tiles. Generally the floors are in poor to very [poor] condition. Many of the doors have been removed, but they are generally in good condition and could be reused if needed...trim is largely non-existent. (14).

While the report paints a somewhat grim picture, several important interior spaces are actually well-preserved. This includes the surgical wing, the nursery, the southwest half of the administrative wing, most of the original entrance stairways, and several additional spaces in the hospital core and basement.

#### Original Finishes

According to architectural plans, most of the original hospital had asphalt tile flooring and painted plaster walls and ceilings. There were, however, several important exceptions. The surgical wing had terrazzo flooring, with the twin operating rooms and the delivery room also having 5' ceramic tile wainscoting. In the original emergency room and vestibule (non-existent), terrazzo and quarry tile covered the floors, respectively. Linoleum was used in the hospital's several restrooms, while the service kitchen was covered with a special "greaseproof tile." Front entrances received quarry tile; rear entrances and mechanical spaces had concrete floors. Acoustic ceiling tiles deadened sounds in some spaces (corridors, waiting rooms, the dictation room, the nursery, the pediatric playroom, and the labor room), while keeping it out of others (the business office and superintendent's office). In accordance with the hospital's Mid-Century Modern design, trim work was limited. Windows, for instance, are simply recessed into the

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interior wall face, while it appears most interior doorways lacked trim. Some rooms do retain rubber baseboards or reveal scarring from the removal of radiators or equipment. While some of these original finishes are gone, others remain largely intact.

The hospital's wood interior doors are lovely examples of Mid-Century Modern design. All have the iconic "blonde" or "honey" wood finish, with some being solid planes and others having a rectangular upper light. Several of the doors also retain their original (or historic) black stenciling. These include doors to the laboratory, dark room, janitor's closets and operating rooms I and II. Surviving door hardware (hinges, closers and handles) is typically brass, with handset pulls, push panels and door knobs all in use. This style was closely followed during remodeling and expansion, making it somewhat difficult to differentiate original doors from those installed more recently.

First Floor: Primary Corridor

The first floor of Livingston Memorial Hospital is arranged around a series of wide (8' to 12') corridors. A primary corridor runs northwest to southeast through the surgical wing, hospital core and pediatric wing. There are two secondary corridors that run parallel to the primary corridor. The first starts at ER Addition entrance and continues southwest until reaching the administrative wing. The second runs through the Rooms Addition between the maternity and nursing wings. There are also three secondary corridors that run perpendicular to the primary corridor. The administrative corridor travels northeast from the hospital core, while the maternity and nursing corridors travel southwest.

The long primary corridor has can be divided into three major sections: the pediatric wing, the hospital core and the surgical wing. The pediatric wing corridor can be further divided into two sections that are separated by original double wood fire doors. The doors have upper lights with wired glass and original brass handset pulls. At its southwest end, the pediatric wing corridor has its original asphalt tile flooring with rubber baseboards. The plaster walls are painted blue, but the ceiling has been removed [Photo 26]. The original pediatric playroom is situated at the northwest southwest corner and there are three patient rooms [Photo 27]. A charming floral and butterfly pattern wall paper is exposed near the ceiling in one of the rooms. A wood door with a wire mesh glass light at the end of the corridor opens to an enclosed stairway entrance [Photo 28]. The concrete stairway is flanked minimalist "blonde" wood handrails attached to the wall with brass brackets. There is a vintage Trane wall radiator at the bottom of the stairs.

To the northeast of the fire door, the floor of the pediatric wing is carpeted and the plaster walls are painted with a series of whimsical scenes [Photo 29]. This section originally held two patient rooms and a utility room on its northeast side and a four-bed ward flanked by two rooms on its southwest side. This configuration is still visible, but have been modification. Most notably, the patient room at the northwest corner is now partially open and connected to the room behind it (part of the original nursing wing hyphen and Rooms Addition) [Photo 30 and 39].

The transition from pediatric wing to hospital core occurs where the long primary corridor intersects with the nursing wing [Photo 39]. Here the floors are carpeted, the ceiling is removed and the walls are painted white with a turquoise strip. Some doors in the hospital core are also painted white. A modern double metal fire door bisects the primary corridor just before it meets the administrative wing [Photo 32]. To the southeast of this fire door, the hospital core retains some of its original layout. There is an especially well-preserved area on the northeast side of the corridor between the pediatric and administrative wings. This includes a slender perpendicular corridor with restrooms and a janitor's closet and the entrance to the hospital's split-level stairway [Photo 33]. The split-level stairway has a landing at the grade level entrance and parallel stairs running up and down. Red quarry tile covers the stairs. A minimalist wood handrail attached to the wall with brass brackets flanks the stairs to the elevated first floor. The basement stairs have a single handrail of identical design on their outer (northeast wall) [Photo 34].

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The primary corridor continues past the administrative wing and through the remainder of the hospital core [Photo 35-37]. This area originally featured a relative open space flanked by a service kitchen and nurse's station to the southwest and a large mechanical room to the northeast, but it has been significantly altered. The existing spaces are largely devoted to storage, although there are a few interesting features like dumbwaiters for meals and clean linens and a laundry chute [Photo 38]. There are two additional fire doors in this section of the corridor. The fire doors are situated approximately 25' away from each other, with the first one being 25' northeast of the administrative wing. Both contain double wood doors with slender rectangular lights and modern metal push bars. The carpeting ends in this section nearest the surgical wing, revealing the original asphalt tile flooring. [Photo 40].

The primary corridor transitions into the surgical wing near its northwest end. Here, the plaster walls and ceilings are still intact. Original terrazzo flooring runs through the surgical corridor and the labor and delivery corridor [Photo 42]. The surgical corridor is composed of twin operating rooms at its northwest end. A scrub-in area, mechanical room and sterilization room separate the operating rooms. The wall at the scrub-in area is scarred with the marking of twin sinks [Photo 43]. Massive windows provide ample light in the operating rooms, which retain their original green ceramic tile wainscoting [Photo 44-45]. The remainder of the surgical corridor is situated in front of the northeast operating room. It originally included a cleanup room, janitor's closet and two small storage rooms, along with men's and women's locker rooms. The labor and delivery corridor runs along the southwest side of the surgical wing. It includes a labor room and delivery room separated by a scrub-in and sterilization space. There is also a janitor's closet, cleanup room and toilet. Like the operating rooms, the delivery room has a massive window (currently painted over) and green ceramic tile wainscoting [Photo 46]. While the surgical corridor has seen some alterations, including the removal of equipment, furnishings and plumbing, it retains excellent overall integrity.

First Floor: Administrative Corridor

The administrative corridor runs from the primary corridor in the hospital core to the original main entrance. It retains good historic integrity at the main entrance and along its southeast side. The northwest side, in contrast, is significantly altered. In general, the administrative corridor has newer marmoleum flooring with a centered diamond motif. The plaster walls are painted white and most of the ceiling has been removed. The corridor is bisected by an original double wood fire near its northeast end. Each door has a rectangular upper light with wired glass. There are brass handset pulls on the exterior (northeast) side of the doors and brass push panels on the interior (southwest) side. The fire door assembly also includes a low-profile blonde wood surround [Photo 47].

A curtain wall with blonde wood framing makes up the southeast elevation of the main entrance foyer [Photo 48]. The curtain wall has six columns and three rows that create a grid pattern. In the four southeast columns the top two rows have stationary glass panes, while the bottom row has a blonde wood panel. (Historic photographs show the bottom row original held glass as well). Double doors are situated in the two northwest columns below a stationary pane of glass. Inside the curtain wall, a perpendicular flight of eight stairs leads up the elevated first floor. The slender space between the stairs and the curtain wall is covered in blonde wood. Angular chrome railings flank the staircase. The floors and staircase are covered in red quarry stone tile. Walls in the entrance vestibule are plaster with a textured wallpaper wainscoting. The ceiling appears to be acoustic tile [Photo 49]. There is vintage Trane radiator centered on the northwest wall. Double wood doors originally separated the foyer from the administrative corridor, but they have been removed. Overall, the main entrance foyer retains much of its Mid-Century Modern character and is a significant interior space.

The short section of the administrative corridor between the main entrance and the fire door assembly retains its plaster ceiling [Photo 47]. Originally, this section accessed the superintendent's office to the southeast and the waiting room / lobby to the northwest, but those spaces have been altered. Moving



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inside the fire door, the rooms to the southeast retain some of their original features [Photo 50]. The first room encountered on this side of the corridor is the original laboratory [Photos 51-52]. The wood door has an upper light with wired glass and retains its original black "LABORATORY" stenciling. Inside the door is a large expanse that includes the laboratory and what was the business office. A large square column remains in place to indicate the interior wall that once divided the two spaces. The floor of laboratory / business office is covered in various patterns of asphalt tile that is in poor condition. The walls and the ceiling in the original laboratory are plaster, while in the business office the walls are plaster but the ceiling is acoustic tile. Original metal windows add to the historic character of the laboratory / business office. Moving southwest from the laboratory is the original radiography room, a small dark room and a patient room that was converted into a second emergency room [Photo 53]. The dark room has an original wood door with a small, painted-over light. It retains its original black "DARK ROOM" stenciling. The converted emergency room has a wide wood door with black stenciling that reads, "EMERGENCY 2."

Moving southwest from the main entrance, the northwest side of the administrative corridor originally housed the waiting room / lobby, restrooms, a dictation room, a janitor's closet, a splint room, the emergency operating room and the emergency vestibule. While some vestiges of this floor plan remain, this side of the administrative corridor was significantly altered during the c. 1987-1989 remodeling project. At that time, most rooms in this area were reoriented toward the ER Addition.

First Floor: ER Addition Corridor

The ER Addition corridor follows the path of the original emergency vestibule, but pushes farther to the northwest. It terminates on its northwest end in a metal curtain wall entrance foyer and on its southeast side at the administrative corridor [Photo 54]. It is also connected to the hospital's primary corridor by a short hallway that exits just southwest of the surgical wing [Photo 55]. The ER Addition corridor has the same diamond motif flooring used in the administrative corridor. Instead of plaster, however, the walls of this newer addition are drywall. The ceiling in the ER Addition corridor has been removed.

The main entrance to the ER Addition is located just inside the entrance vestibule at the northwest end of the corridor [Photo 56]. It contains double wood doors in a metal frame. There is a short section of wood panel wainscoting on the southwest wall directly across from this entrance. In general, the interior of the ER Addition is characterized by drywall and wood doors in metal frames [Photo 57]. A short corridor runs from the double wood doors to the back (northeast) end of the addition. There are two large rooms to the northwest of this interior corridor, and a third large room in the northeast corner. Two smaller rooms in the southwest corner of the addition are oriented toward the administrative wing.

First Floor: Rooms Addition Corridor

This short corridor runs directly behind the original rear (southwest) elevation of the hospital core [Photo 58]. It was built in c. 1987 to add four addition patient rooms in the hospital's rear courtyard. On its northwest end, the Rooms Addition corridor terminates at a door cut into the angled wall of the maternity wing hyphen [Photo 59]. It terminated at the nursing wing on its southeast end. The floor of the corridor is covered in carpet and the walls and ceiling are drywall. A turquoise stripe is painted on the wall. The patient rooms are situated along the southwest side of the corridor. Each room has a solid wood door, a small bathroom and a side-by-side casement window [Photo 60].

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### First Floor: Maternity Corridor

The maternity corridor runs between the Rooms Addition corridor and the southwest end of the maternity wing. Overall, the maternity wing retains good historic integrity. The corridor, nursery and most of the patient rooms have their original asphalt tile flooring, as well as their plaster walls and ceiling finishes. A maroon stripe is painted along the corridor walls. The maternity wing also retains most of its original metal windows. These are generally four- or two-part windows with tall upper lights above a short awning lights. Each awning sash is opened with two interior, lever-style latches.

Double wood fire doors with wire glass lights and brass push panels separated the maternity corridor from the Rooms Addition [Photos 59 and 61]. The original nursery is located just inside the fire doors along the northwest side of the maternity corridor [Photo 62]. It is comprised of two large rooms separated by a smaller work room. Each large room has a wide solid wood door with a brass handset handle. A recent lever handle was also added to the door accessing the southwest room. Each large room has a door to the central workspace. These are identical wood doors with upper lights and brass handset pulls. In addition to these doors, the walls separating the work room from the nursery rooms have identical openings, suggesting there were interior windows at one time. The work room is accessed from the nursing corridor by a wood door with an upper light and a lever handle. Ceilings in the nursery rooms are the original acoustic tile, while the ceiling in the work room has been removed.

Originally there was a series of workspaces across the hall from the nursery, including a bottle washing and preparation area and a "suspect nursery." There was also a nurse's station situated directly behind (southwest of) the nursery. However, most of these work spaces were eventually converted into patient rooms. The southwest end of the maternity corridor retains its original patient rooms [Photo 63]. The one exception is the original four-bed ward along the southeast side of the corridor. This already large room was expanded and significantly modified [Photo 64]. A final noteworthy feature of the maternity corridor is the enclosed entrance stairway at its southwest end [Photos 65-66]. It is accessed through a wood door with a wired glass upper light. The concrete stairs run perpendicular to the corridor, leading to an exterior door on southeast wall. Minimalist blonde wood handrails with brass brackets flank the stairs. There is also a vintage Trane radiator at the bottom of the stairway. A second exterior door was cut into the rear (southwest) wall of the entrance foyer at the first floor landing. This doorway provided access to a series of three modular units that were once attached to end of the maternity wing.

### First Floor: Nursing Corridor

The nursing corridor runs between the hospital's primary corridor and the southwest end of the nursing wing [Photo 67]. Patient rooms run along each side of the nursing corridor. In general, patient rooms have asphalt tile floors and plaster wall and ceiling finishes. Most rooms have individual bathrooms and are accessed through wide wood doors with push handles [Photos 68-70]. The floor of the nursing corridor is covered in carpet and the walls are finished in plaster. A blue stripe runs along both walls. The ceiling of the nursing corridor has been removed, along with some room ceilings. Original windows in the nursing wing were replaced with metal casement sashes during the c. 1987-1989 remodeling project.

There is an enclosed entrance stairway at the end of the nursing wing [Photo 71]. It is separated from the main corridor by double wood doors with small wired glass lights and metal push bars. The concrete stairs run perpendicular to the corridor, leading to an exterior door on the southeast wall. A simple tubular chrome handrail flanks the stairs. There is a vintage Trane wall radiator near the bottom of the stairway.

### Basement

The 11,450-square foot basement houses several features that were essential to the function of Livingston Memorial Hospital. The original section of the basement has a T-shaped plan and is situated directly

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under the hospital core and administrative wing. There is also a newer section under the c. 1987-1989 ER Addition. The basement has four points of entry: the split-level entrance in the hospital core, an enclosed staircase off the southwest corner of the administrative wing, a concrete stairwell at the junction of the surgical and maternity wings, and a stairway on the northeast elevation of the ER Addition.

The basement has perpendicular corridors that intersect at the split-level entrance in the hospital core. The primary corridor runs parallel to the hospital core, while a secondary corridor runs under the administrative wing [Photos 72-74]. The hospital cafeteria, lounge and laundry facilities are situated to the southwest of the primary corridor. The secondary corridor passes office space on its way to the original boiler room at its northeast end. There is (or was) an elevator situated at the junction of the hospital core and the administrative wing. In the basement it is accessed through double solid wood doors on the southeast side of the secondary corridor. One of these doors still retains its black "ELEVATOR" stenciling [Photo 74]. There is also a freight elevator at the northeast end of the ER Addition.

The corridors in the basement have asphalt tile flooring and plaster walls and ceilings. Basement rooms have an assortment of finishes. The boiler room has concrete walls and floors [Photo 77]. It houses several large pieces of mechanical equipment and has a brick incinerator. The office space to the southwest of the boiler room has concrete floors and an acoustic tile ceiling [Photo 76]. Drywall, a cement floor and an acoustic tile ceiling characterize the large storage room under the ER Addition [Photo 75]. Moving across the hall, the cafeteria has linoleum flooring and plaster wall and ceiling finishes [Photos 78-79]. There is tile flooring in the cafeteria kitchen, which still retains much of its stainless steel, industrial-grade equipment [Photo 80]. The lounge area to the northwest of the kitchen has carpet flooring and a combination of plaster and acoustic tile ceilings [Photo 81]. In the laundry room, there is a concrete floor and the walls and ceiling have a plaster finish [Photos 82-83]. There are still three industrial-grade washers and a massive rolling iron machine (or mangle) in the laundry room. In general, the basement has the same type of wood doors that are found on the first story. Some are solid wood, while others have an upper light. Door handles range from recent levers to vintage brass knobs and handsets.

### **LIVINGSTON MEMORIAL HOSPITAL: Condition, Integrity and Preservation**

Overall, Livingston Memorial Hospital retains sufficient physical integrity to convey its significant association with the development of healthcare in Livingston and the transformative impact of the federal Hill-Burton hospital construction program in Montana. Despite several alterations over the course of its sixty years of service, the hospital still clearly reflects its early 1950s construction date and original Mid-Century Modern design. The hospital stands on its original location. The setting of the hospital has changed, but only because it was one of the first structures built at the southwest end of town. In this sense, the hospital drove development in this section of Livingston. Development around the hospital is, for the most part, complementary to its Mid-Century Modern design and original function. This includes the Modern-style Werner Addition, platted immediately to the south of the hospital in 1953, and two additional healthcare-related buildings: a medical clinic (c. 1962) and retirement home (c. 1971). There have also been a few changes to the hospital site (Block 29 of the Park Addition to Livingston). This includes the construction of three buildings: a small groundskeeper shed (c. 1975), a small utility building (Home Oxygen, c. 1975) and the Mental Health Building (c. 2004). Of these, only the Mental Health Building is truly invasive to the hospital's immediate setting. It is, however, situated near the back of the block and only obscures two of the hospital's several secondary elevations.

Two additions built during a multi-phase remodeling project in c. 1987-1989 pose the greatest challenge to the hospital's historic integrity. While the small Rooms Addition in the rear courtyard is relatively minor, the larger ER addition at the north corner of the hospital did significantly impact the overall design. It covered two important elevations (the northwest side of the administrative wing and the

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northeast side of the surgical wing) and also shifted the main entrance. However, the original main entrance at the northeast end of the administrative wing is still easily recognizable despite the loss of its stylish, diagonally-oriented canopy. The excellent interior integrity of the entrance foyer also softens the impact. Furthermore, the c. 1987-1989 ER entrance actually follows the orientation of the hospital's original emergency entrance. It is also important to note that the additions were designed by the same architectural firm responsible for the original hospital building (Cushing & Terrell / CTA). The additions are sympathetic in materials and design, but also clearly distinguishable from the original building. The newer sections, for instance, have similar window bands to the original hospital, but instead of limestone trim they are framed with rowlock brick.

It is also important to consider the integrity of Livingston Memorial Hospital in its historic context and in comparison to other Hill-Burton hospitals in Montana. The hospital served Livingston and Park County for sixty years (1955 – 2015). During this period, the population of Livingston remained relatively steady, fluctuating between a high of 8,229 in 1960 and a low of 6,701 in 1990. When coupled with the fast pace of medical innovation during this timeframe, it is expected that the hospital would expand and evolve. Moreover, the integrity of Livingston Memorial Hospital compares favorably to other Hill-Burton hospitals built in Montana between during the program's first decade (1946-1956). A cursory survey of other Hill-Burton hospitals reveals that most have been extensively modified. Even those that are especially well-preserved, such as Wheatland Memorial Hospital in Harlowton, have non-sympathetic additions. Livingston Memorial also retains better overall integrity than Carbon County Memorial Hospital, the other Hill Burton hospital designed by Cushing & Terrell during this period.

Livingston Memorial Hospital also retains much of its original construction materials and workmanship. Most significant, are the buff brick walls and limestone-framed window bands. Although most of original windows were replaced in c. 1987-1989, there are still several extant examples in the maternity and administrative wings. The hospital also retains its original wood-frame window wall entrance. The integrity of materials and workmanship continues in the hospital's interior. While the floor plan was altered over the years, the original functions and layout are still recognizable. There are also several well-preserved interior spaces, such as the surgical wing, the laboratory, the nursery and all of the original entrances. Extant interior finishes in the surgical wing include terrazzo floors, plaster walls and ceilings, and ceramic tile wainscoting. A finally noteworthy interior feature is the hospital's surviving doors. With their solid wood construction and "honey" or "blonde" coloring, these doors are a wonderful reminder of the Mid-Century Modern aesthetic. In sum, the well-preserved physical integrity of Livingston Memorial Hospital evokes a powerful sense of its period of historical significance. As such, the building also possesses the more abstract components of historic integrity: feeling and association.

Furthermore, Livingston Memorial Hospital also retain excellent structural integrity. According to a Preliminary Architectural Report under preparation by NE45 Architecture:

The walls are in good condition with minimal cracking at the masonry joints. All masonry units are intact and in good condition. Caulking and sealants at control points appear in fair condition.

Some typical maintenance is needed...The building utilizes conventional strip footing and stem walls. Foundation movement or indications of structural distress were not identified during the field assessment. Some minor cracking [has] occurred as a result of the lack of expansion joints. This is typical for 1950's construction. Overall, the foundation appears to be in good condition. (15).

In short, Livingston Memorial Hospital is an excellent candidate for historic rehabilitation. It is structurally solid and possesses sufficient integrity to convey its historic significance. On the other hand, the level of integrity is not so high that necessary alterations will threaten its architectural significance. In

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fact, if done well, the rehabilitation has the potential to vastly improve the overall appearance of the building and enhance its historic integrity. Finally, the former hospital possesses the space and interior layout required to accommodate its proposed post-rehabilitation function: rentable affordable housing units.

## **NON-CONTRIBUTION BUILDINGS**

### Mental Health Building, c. 2004

This relatively large (approximately 60' x 70') building was constructed on the west corner of the lot in c. 2004 [Photo 25]. It is a one-story, side-gable frame structure clad in horizontal vinyl siding. The first-story is well above grade, and the area below the main building face is covered in vertical vinyl skirting. The main building is beige-colored, while the skirting is white. Asphalt shingles cover the gable roof, which has slightly projecting eaves and rakes. Both have vinyl fascia and soffits. The building sits on a concrete slab foundation. Unlike the other small buildings on the block, the orientation of the Mental Health Building is aligned with the city grid and not the hospital.

The elevated main entrance to the Mental Health Building is offset to the southwest on the front (northwest) elevation. It is reached by a substantial wooden ramp structure with a wood and tubular metal railing. The ramp runs across the entire elevation northeast of the entrance, which holds a metal-framed glass door. Two evenly-spaced, rectangular windows with stationary lights are found on either side of the entrance. There is a fifth window near the northeast end of the front elevation.

There is a secondary entrance near the northeast end of the southwest gable end. It contains a solid metal door and is reached by a short wood stairway with a wood and metal railing. There are four randomly-spaced rectangular windows with stationary lights to the northwest of the entrance. The northeast gable end and rear (southeast) elevation are relatively simple. Three evenly-spaced rectangular windows with stationary lights are situated along the northeast gable end. The longer rear elevation has six windows of an identical design.

### Home Oxygen Building, c. 1975

This is small (approximately 42' x 30') front-gable, frame structure that housed the hospital's home oxygen program [Photo 24]. It is situated off the northeast elevation of the hospital between the administrative wing and hospital core / pediatric wing. This area was originally used as a semi-circular drive for pickup and drop-off at the main hospital entrance. The utility building has a gable roof with overhanging boxed eaves. On the gable ends, there is a slightly projecting rake. The roof is covered with asphalt shingles. Exterior walls are clad in wide vertical wood siding. It is painted a light yellow-beige, which matches the wood siding used on the hospital. The building sits on a concrete slab foundation. This structure is not visible in a c. 1974 aerial photograph, but does show some signs of age. It was, therefore, assigned a construction date of c. 1975.

The centered entrance in the front (northwest) elevation holds double doors made with the same vertical wood paneling used for the exterior walls. There is a small, one-over-one window in the top half of the southwest door (which may be fixed in place). The northeast door has a modern metal lever handle and swings inward. A third entrance is found in a cutaway at the north corner of the front elevation. This entrance, which is located in the northwest wall of the cutaway, contains a modern vinyl door with two lower panels and a large upper light. There is also a small two-light window in the northeast wall of the cutaway. Two thin wood posts support the roof over the cutaway. Here, the roof structure is open with exposed rafters.

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The northeast elevation of this building features two evenly-spaced windows. The northwest window has side-by-side lights, while the southeast window has a one-over-one configuration. On the other side elevation (southwest) there is a single square opening near the back (southeast) end. It is situated near the top of the wall face and has a heavy wood frame. Currently filled with wood paneling, the original purpose of this opening is unclear. An entrance and window are found at the southwest end of the rear (southeast) elevation. The slightly elevated entrance is reached by a short perpendicular ramp with a simple tubular metal handrail. A modern vinyl door with two lower panels and a rectangular light fills the rear entryway. The window is located immediately northeast of the entrance. It holds side-by-side lights.

Groundskeepers Shed, c. 1975

This small (approximately 20' x 14'), one-story, frame structure stands at the south corner of the hospital site. [Photo 21]. It has a shed roof with a boxed, overhanging eave that slants downward from front (northeast) to back (southwest). Sheet metal paneling currently covers the roof. The building is clad in wide vertical wood siding and sits on a concrete slab foundation. Because the shed does not appear in an aerial photograph from c. 1974, but still presents an older appearance, it is dated c. 1975. Overall, this simple shed is in keeping with Mid-Century Modern design of the hospital. It is painted a light yellow-beige color that matches the wood siding on the hospital and the utility building.

The front (northeast) elevation contains a centered entrance with double wood doors that swing out on hinges. The door has a single horizontal brace and is of the same vertical wood siding that covers the building. One interesting door feature are four small, triangular, wood panels situated under the metal hinges. The back (southwest) elevation has a centered window opening with a simple wood frame. The opening holds a stationary glass pane. The side (northwest and southeast) elevations of the shed lack fenestration.

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## 8. Statement of Significance

### Applicable National Register Criteria

(Mark "x" in one or more boxes for the criteria qualifying the property for National Register listing.)

- ☒ A. Property is associated with events that have made a significant contribution to the broad patterns of our history.
- ☐ B. Property is associated with the lives of persons significant in our past.
- ☐ C. Property embodies the distinctive characteristics of a type, period, or method of construction or represents the work of a master, or possesses high artistic values, or represents a significant and distinguishable entity whose components lack individual distinction.
- ☐ D. Property has yielded, or is likely to yield, information important in prehistory or history.

### Criteria Considerations

(Mark "x" in all the boxes that apply.)

- ☐ A. Owned by a religious institution or used for religious purposes
- ☐ B. Removed from its original location
- ☐ C. A birthplace or grave
- ☐ D. A cemetery
- ☐ E. A reconstructed building, object, or structure
- ☐ F. A commemorative property
- ☐ G. Less than 50 years old or achieving significance within the past 50 years

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**Areas of Significance**

(Enter categories from instructions.)

Health/Medicine

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**Period of Significance**

1955 - 2015

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**Significant Dates**

February 19, 1955 - dedication

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**Significant Person**

(Complete only if Criterion B is marked above.)

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**Cultural Affiliation**

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**Architect/Builder**

Cushing & Terrell (forerunner of CTA, Inc.),

Ralph H. Cushing

Everett O. Terrell



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**Statement of Significance Summary Paragraph** (Provide a summary paragraph that includes level of significance, applicable criteria, justification for the period of significance, and any applicable criteria considerations.)

Livingston Memorial Hospital is significant at the local level under National Register Criterion A in the area of health-medicine. The hospital opened its doors to patients on February 28, 1955 and served the community of Livingston, Montana for the next sixty years. As such, the period of historical significance begins in 1955 and ends in 1967. This period extends from the hospital's opening through the "50 years from the present" cutoff date established by the National Park Service for historical significance.

In the area of health-medicine, Livingston Memorial Hospital is importantly associated with the evolution of healthcare in Livingston, Montana from its modest beginnings in 1882 through the construction of a state-of-the-art, \$43.5 million hospital in 2015. Within this evolution, Livingston Memorial Hospital represents the first significant community investment in healthcare infrastructure. Incorporated in December 1946, the Livingston Community Hospital Association eventually raised \$415,996.72 in community donations toward construction of the new hospital. The remainder of the construction funds, which totaled \$276,216.54, came from a federal aid program initiated by the Hill-Burton Act of 1946. The hospital's association with the Hill-Burton Act, which transformed the American healthcare system following World War II, provides an additional measure of historical significance in the area of health-medicine. Livingston Memorial Hospital is also significant for its community impact. The hospital and its staff supported countless patients through some of life's most intimate moments: illness and recovery, birth and death. Livingston Memorial brought modern medicine to Livingston and Park County, touching the lives of every individual within its reach.

Livingston Memorial Hospital also possesses great architectural significance, but lacks sufficient physical integrity to be considered individually eligible for the National Register under Criterion C. That said, it remains an important local example of Mid-Century Modern architecture, as well as an enduring reminder of the Hill-Burton's Act's physical legacy. Montana's Hill-Burton hospitals were shining examples of Mid-century Modernism. Long, low brick structures with flat roofs and minimal ornamentation, they reflected the Modern Movement's clean lines and rationalized aesthetic. Their designs originated from Montana's leading architectural firms, including J. G. Link, H. E. Kirkemo and Cushing & Terrell. Based in Billings, Montana, Cushing & Terrell designed two early (pre-1956) Hill-Burton hospitals: Livingston Memorial Hospital and Carbon County Memorial Hospital in Red Lodge. Of the eighteen Hill-Burton hospitals built in Montana between 1946 and 1956, Livingston Memorial Hospital is the largest, while also being one of the best preserved. Like most well-used hospitals, it has undergone several alterations, but exterior changes are generally compatible with the building's original Modern design. Furthermore, Livingston Memorial appears to be the first Hill-Burton hospital in Montana to show the influence of Exaggerated Modernism, particularly in its complex, multi-wing plan, overhanging eaves, and the detached, sloped roof over the original surgery wing. A more expressive take on Mid-20<sup>th</sup> century architecture, Exaggerated Modernism broke free from the austere cubism of the early 1950s and pushed the boundaries of building shape and design.

**Narrative Statement of Significance** (Provide at least **one** paragraph for each area of significance.)

#### **CRITERION A: The Evolution of Healthcare in Livingston, Montana**

In *The Care of Strangers: The Rise of America's Hospital System*, historian Charles E. Rosenberg writes:

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To most observers, the twentieth century hospital seems an inevitable, if perhaps imperfect institution, one that grew unavoidable out of the interaction between social necessity and an emerging technical capacity. Despite this aura of inevitability, however, both logic and history emphasize that the American hospital's development has been contingent. (10).

This certainly describes the hospital that opened its doors on February 28, 1955 in Livingston, Montana. The hospital's existence—which now seems inevitable—was contingent on several factors: community need and support, fundraising, professional management and medical care, advances in architectural planning and medical technologies, and generous federal policies that promoted extraordinary socio-economic development in postwar America. Moreover, the construction of Livingston Memorial Hospital was also the result of community expectations based on past experience and future aspirations. On one hand, the community had become accustomed to quality private healthcare through a network of trusted doctors, nurses and facilities. On the other hand, Livingston—like the entire nation—emerged from World War II focused on modernization. In essence, the hospital's construction represents a community thoroughly committed to securing its place in America's flourishing Postwar Era. Without much incident, the hospital remained essential to Livingston's health and prosperity for the next several decades.

In the late 20<sup>th</sup> century, Livingston suffered a severe economic setback with deregulation of the nation's railroads. The Northern Pacific (and later the Burlington Northern) had operated a massive shop complex in Livingston since the town's founding in 1882, but the shops permanently closed in 1986. This economic strain threatened the town and its hospital through the early 2000s, but today both stand on solid footing. Naturally, Livingston's newfound vitality spurred a desire for better facilities and a new, \$43.5 million hospital opened in 2015. Today, Livingston Memorial Hospital stands as tribute to the town's postwar ambitions and continued permanence and viability. After a historically sensitive rehabilitation, the former hospital will continue to serve the community as a 34-unit affordable housing complex.

Early Healthcare in Livingston, Montana: 1882 – 1901

Platted by the Northern Pacific Railroad in December 1882, Livingston quickly became an important division point along the nation's northernmost transcontinental railroad. The Northern Pacific pledged to build an extensive complex of brick repair shops on the north side of town, which, according to the *Livingston Enterprise* in July 1883, would, "give constant employment to hundreds of well paid artisans who with their families, will make Livingston their homes, thus furnishing a large local trade to our merchants from this source alone." (7-28-1883). Adding to the economic prospects of the new town was its proximity to Yellowstone National Park, already a bona fide tourist destination when the Northern Pacific completed its main line in 1883. It was primarily through the corporate maneuvering of the Northern Pacific, then, that Livingston was destined to become both a hardworking railroad town and a cosmopolitan tourist outpost. The town also benefited from the creation of Park County in 1887. A natural selection for county seat, Livingston saw increased activity with rural residents visiting often to record deeds, stake mining claims, pay taxes and conduct other county-level business.

Livingston grew quickly during its first decade. An informal population count in 1883 yielded 891 residents, and this number swelled to nearly 3,000 by 1890. It was a lively and diverse community. In addition to the railroad workers and merchants—who hailed from nearly every European nation and American state—there was also a substantial Chinese population, as well as handful of other ethnic and racial minorities in search of economic opportunity along the Northern Pacific's transportation frontier. Women also played a significant role in the development of Livingston's social and economic character as entrepreneurs or through an active network of church and civic organizations. Livingston's large transient population, which on any given day might include cowboys, shearers, ranch families,

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miners, common laborers, Native Americans or posh tourists, also added another element of diversity to the local scene.

At some point in their life most Livingston residents would require healthcare, but the town's first hospital did not open until 1901. Instead, the medical needs of the community were met by a network of private doctors and nurses during its first few decades. In this way, Livingston was no different than other communities of its size. Through most of the 19<sup>th</sup> century, hospitals were found only in the nation's largest cities and were typically associated with charity. As Rosenberg notes:

In 1800, the hospital was still an insignificant aspect of American medical care. No gentleman of property or standing would have found himself in a hospital unless stricken with insanity or felled by epidemic or accident in a strange city. When respectable people fell ill, they would be treated at home. (4).

On the other hand, sick individuals unable to pay a doctor's fee, "were most likely to find themselves in an almshouse, not a hospital." (Rosenberg, 4). Transient populations lacking social ties in the community were particularly vulnerable to institutionalization in the almshouse or county poor farm. While these institutions were a step up from earlier systems (like indentured servitude or "outdoor relief"), they still left sick and poor individuals open to squalid conditions, mistreatment, and exploitation. The dichotomy between respectable homecare and institutionalized poverty certainly existed in Livingston, although there was significant overlap between the two.

The burgeoning town of Livingston attracted a handful of doctors, who were available for home visits, medical emergencies, and death inquests. By 1884, there were four physicians with offices in downtown Livingston and this number remained relatively steady until Livingston experienced a population boom in the early 1900s. Of these early physicians, Dr. Robert D. Alton and Dr. W. H. Campbell had the longest tenure and the greatest impact. Dr. Alton came to Livingston in 1883 as a physician for the Northern Pacific Railroad and eventually went into private practice. Campbell arrived in November 1882, establishing a drug store and medical practice. Professional nurses were also working in early Livingston, including a Mrs. R. Sturgeon and a "Miss Jones." The latter, who "had extensive experience as a nurse in London," moved to Livingston in 1890 and worked both independently and under the direction of the town's physicians. A brief survey of the local newspaper reveals the diversity of medical issues the community encountered. In May 1892 alone, Livingston doctors and nurses faced the death of an infant and a four-year-old boy, two residents afflicted with a "serious illness," the amputation of fingers following a railroad accident, two surgeries to remove tumors, and the six childbirths. In an effort to better serve their community, area doctors established a Park County medical organization. Their first meeting was held on November 22, 1889 in Livingston at the home of Dr. Alton.

At the same time, Park County began to care for its most destitute residents with the establishment of a poor fund and a poor farm. Derived from county taxes, the poor fund reimbursed community members for a variety of services related to caring for the county's unfortunate "paupers." In September 1887, the county paid out nearly \$450.00 for the following acts: boarding paupers, shaving a corpse, nursing paupers, furnishing medical supplies and merchandise to paupers, and burying two paupers. In addition, the county also employed the "lowest responsible bidder" as a physician to the poor. In 1887, that responsibility fell to Dr. H. Robarts, who was also the county corner, for a salary of \$30.00 per month. The effort to establish a county poor farm began in early 1889 and was intensified by an urgent recommendation from the Grand Jury of District Court in October of that year. "In regard to the county paupers," the jury reported:

...the arrangements for keeping them [are] reasonably good, considering that they are kept in the city of Livingston, but we earnestly recommend, as a matter of economy to the

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county, that some place outside the city limits of the county seat be procured at a reasonable expense, as a poor farm. (LE, 10-5-1889).

The County moved quickly following the jury's recommendation, purchasing a 160-acre farm about thirteen miles from Livingston in early November. The first poor farm, however, was highly unsatisfactory. Just a few months after its purchase, the jury found nine "inmates" at the poor farm, all of whom were under a physician's care, "living in quarters that were entirely too small and low," and lacking in sufficient ventilation. Moreover, the great distance of the poor farm from Livingston rendered it "expensive and often impossible" for the county physician to make regular visits. (LE, 4-19-1890). At that time, the jury recommended no further improvements be made to the property, and that the county look for a new farm much closer to Livingston. A new property, located just three miles west of town, was purchased in 1891 with a grand \$5,000 "poor house" built in 1892. Architecturally, the 1892 poor house was a Richardson Romanesque gem designed by the Galbraith & Fuller, the same firm responsible for the Montana Building at the 1893 World's Columbian Exhibition in Chicago.

In essence, the Park County Poor Farm was Livingston's first hospital. While Livingston's "respectable" citizens were treated by private doctors at home, the sickly poor were sent to the Poor Farm. Here too, Livingston fit within the broader development patterns of American healthcare. "Although envisioned as a 'receptacle' for the dependent and indigent," writes Rosenberg in *The Care of Strangers*, "the almshouse had by the late eighteenth century become in part a municipal hospital." (4). Following the Civil War, however, the concept of specialized institutions devoted solely to the practice of modern medicine for the benefit of all citizens would start to gain widespread acceptance in the United States.

(Sources: *Livingston Enterprise*, 7-28-1883, 2-16-1884, 6-11-1887, 9-17-1887, 10-5-1889, 11-2-1889, 11-23-1889, 4-19-1890, 6-21-1890, 4-25-1891, 5-7-1892, 5-14-1892, 5-21-1892 and 5-28-1892; Livingston Enterprise Souvenir; Finding Aid, Dr. Robert D. Alton Records; *The Care of Strangers*).

#### From Home to Hospital: Healthcare in Livingston from 1901 through World War II

The dual system of private medical care for most citizens and public care for the impoverished continued in Livingston through the remainder of the 19<sup>th</sup> century. Even so, the transition from homecare to hospital care for everyone was already taking root across the United States. "By the 1880s," Rosenberg notes, "Americans were well aware that many of them no longer lived in small, face-to-face settings" and that, "families would come increasingly to depend on strangers for care at times of sickness and approaching death." (8).

Of course, societal change does not happen overnight. The earliest hospitals were established in large urban centers, such as Philadelphia (1751), New York (1771) and Boston (1811), but they began to spread quickly across the nation in the mid-1800s. These new hospitals were founded by a diverse group of interests. Many evolved from municipal almshouses, but others were established as outright hospitals. San Francisco General Hospital, for instance, had its start with the city's charter in 1850. In other cases, corporate interests drove hospital development. The first hospital in Cheyenne, Wyoming was opened by the Union Pacific Railroad to care for its workers in 1867. Territorial and state governments also entered the healthcare sector, with the establishment of psychiatric hospitals and facilities for the disabled. Finally, there was the dedicated push of religious charity, with Catholic, Protestant and Jewish groups opening hospitals across the nation during the 19<sup>th</sup> century. Equally important to the forces of charity and civic responsibility were several groundbreaking medical advancements. From Civil War battlefields to scientific laboratories, our understanding of medical treatment expanded significantly during this period. The acceptance of germ theory, antiseptics and general anesthetics suddenly made sterilized hospitals a more attractive option for medical care.

In Montana, Christian charity opened most early hospitals. The Sisters of Providence began practicing medicine at St. Ignatius Mission in 1864, while the Sisters of Charity established St. John's Hospital in

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Helena six years later. Both orders set out on “begging tours,” and put the profits toward new hospitals in the Montana towns of Missoula (1873), Deer Lodge (1873), Virginia City (1875), Butte (1881), Anaconda (1889) and Billings (1898). A third Catholic order, the Presentation Sisters, opened Holy Rosary Hospital in Miles City in 1910. The Catholic sisters were followed by the Protestant Deaconess Movement, which opened a hospital at Great Falls in 1902. Deaconess Hospitals eventually opened in six other Montana towns: Butte, Billings, Sidney, Havre, Glasgow and Bozeman. Montana’s territorial and state governments also entered the healthcare field during this period. Between 1880 and 1905, Montana opened institutions for psychiatric patients, veterans, and the physically disabled, while also establishing a Board of Medical Examiners, a Board of Charities & Reform and a Board of Health. Montana’s growing number of hospitals and state institutions brought a new level of compassion and professionalism, but they did not entirely replace the previous healthcare system. Private doctors, nurses and hospitals still operated in many communities, and most counties continued to operate poor farms through the mid-20<sup>th</sup> century.

Despite gaining an estimated 2,225 new residents between 1900 and 1905, Livingston missed out on Montana’s first wave of hospital development. The town was not selected as a prospective hospital site by the Catholic orders, the Deaconess Movement or the State of Montana. Undeterred, the community of Livingston set out to establish its own hospital. The effort was led by Rev. Douglas Sutton of Livingston’s St. Andrew’s Church, Dr. R. D. Alton, and Dr. B.L. Pampel. The three men worked tirelessly to raise \$1,500, the amount required to receive a \$2,000 matching contribution from the Montana Diocese of the Episcopalian Church. Livingston’s first hospital, St. Luke’s, incorporated in October 1901 and opened to the public just a few weeks later. The hospital was located at 422 N. Yellowstone Street in a former residence and staffed by two nurses, a Miss Virden and Mrs. Anna Farrow. Patients could choose from Livingston’s many physicians, who visited the hospital often but also retained their private practice. According to the *Livingston Enterprise* in December 1901, “the people of Park County are already realizing the immense benefit derived from this institution.” St. Luke’s would serve the community for just over a decade.

St. Luke’s Hospital represented the first step in Livingston’s transition from private homecare to hospital care, and several other privately-run hospitals continued the process in first half of the 20<sup>th</sup> century. Of these, the Park Hospital at 121 S. 3<sup>rd</sup> Street was the most significant to formalized hospital development in Livingston. Opened in March 1913 by Dr. G. E. Windsor and Dr. L. E. Safely, it would serve as Livingston’s primary healthcare facility until Livingston Memorial Hospital opened in 1955. Unlike St. Luke’s Hospital, Park Hospital represented a major investment in construction and design. An older residential building was again utilized, but it was completely enveloped by a new two-story brick structure with a Prairie-style façade. “The new hospital is located in the building formerly occupied by Sherriff Kill horn,” reported the *Enterprise*:

...but [it] has been completely remodeled and refitted. The reception room is downstairs and is fitted with the mission style of furniture of the latest design and style. The operating room is in the new part of the second floor and is made sanitary according to the latest requirements in the surgical and medical field. It is well lighted, has cement floor, and all the latest appliances have been installed. (3-10-1913).

Park Hospital was Livingston’s first building constructed solely for the purpose of healthcare. In addition to its modern operating room, the 38-bed hospital also grew to include an X-ray machine and up-to-date maternity ward. Dr. Windsor was particularly proud of the latter, claiming, “as soon as women learn that trained assistance is absolutely essential to good results in obstetrical cases, the sooner our womanhood will be relieved of a vast amount of unnecessary suffering.” (*Centennial Scrapbook*, 89). The interior layout of Park Hospital reveals an increasing emphasis on sterility and technology in the medical field, while its enlarged size indicated the increasing acceptance of hospital care among the general populace.

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By 1909, there were 4,359 hospitals in the United States. “Not only had the hospital spread widely,” explains Rosenberg in *The Care of Strangers*:

...it had become a become a potential recourse for a much larger proportion of Americans; the prosperous and the respectable as well as the indigent were now treated in hospitals; frequently by their regular physicians. And treated in increasingly arcane and impressive ways.... Knowledge, like every kind of work within the hospital, had become increasingly specialized. So too had the hospital as a physical artifact. Early nineteenth-century hospitals were architecturally little different from other large public buildings, but by 1900 the hospital had assumed a characteristic physical form, its internal spaces defined by their functions and those functions understood in technical and bureaucratic terms. (5-6).

Park Hospital, for all its modernity, still could not meet the healthcare needs of everyone in Livingston. Despite Dr. Windsor’s advice, many women remained more comfortable with female nurses and midwives during childbirth and for the treatment of gynecological conditions. Moreover, the poor often sought out compassionate care not always available to them at formal institutions. Meeting this need was a network of women-run maternity and charitable general hospitals located in residential homes. The Lott Hospital was the largest and most important of this group. Born in Illinois on March 28, 1888, Edith M. Lott trained as a nurse in Iowa before moving to Livingston in 1912. She worked at Park Hospital for several years, before opening the Lott Birthing Hospital at 128 S. Yellowstone in about 1926. Always popular due to her compassionate care—it was said she never asked if a patient could pay—Lott soon outgrew this house and moved into a massive Victorian residence at 322 W. Calendar Street. Lott sold her hospital in 1946, and it was run by Dr. W. E. Harris and Dr. R. E. Walker until its patients were transferred to Livingston Memorial Hospital in 1955. Other private hospitals operating in Livingston during the early 20<sup>th</sup> century included the Ellen M. Robinson Hospital at 215 S. 5<sup>th</sup> Street (c. 1925 – 1943), the Westcott Hospital at 222 W. Chinook Street (1910) the Livingston Hospital at Calendar & F Streets (1912), the Livingston Hospital at 322 W. Lewis Street (1914), St. Mary’s Convent Home at 320. S. 3<sup>rd</sup> Street (1927) and two maternity hospitals at 115 & 119 N. 5<sup>th</sup> Street run by “Auntie Red” (1920s).

Private hospitals flourished in Livingston during the first half of the 20<sup>th</sup> century, but the community invested little in their healthcare infrastructure outside of two important exceptions. The County Poor Farm continued to operate and the city purchased a former residence at 323 E. Gallatin Street in 1908 for use as a detention hospital. Also known as the “pest house,” this municipal facility boarded individuals diagnosed with (or suspected of having) a contagious disease until the city sold it in 1917. While important steps in the development of public health facilities, the County Poor Farm and the Detention Hospital served only a fractional segment of Livingston’s population. It would take the massive social upheaval of World War II for Americans to fully embrace the idea of public healthcare.

(Sources: *Livingston Enterprise*, 10-12-1901, 12-7-1901, 3-10-1913, 3-29-1947 and 10-22-2015; *Great Fall Tribune*, 5-10-1956; Women’s History Matters Blog; “History - St. Patrick’s Hospital”; National Register of Historic Places Nominations for Montana Soldiers’ Home, Holy Rosary Hospital, Livingston Detention Hospital and State Capitol HD; *The Care of Strangers*; Livingston, Montana: A Historical and Architectural Context; Livingston City Directories; Centennial Scrapbook).

Organization of the Livingston Community Hospital Association

Residents of Livingston, Montana received a late Christmas present in 1946, when, on December 26<sup>th</sup>, the *Livingston Enterprise* announcing plans to construct a 60-bed, \$350,000 hospital. The decision came after “several months of intensive study of the hospital needs and possibilities of the community.” Led by Ted Stump (manager of the Coca Cola Bottling Co.), T. J. Wegner (president of National Park Bank) and Dr. W. E. Harris (co-manager of the Lott Hospital), the Livingston Community Hospital Association was

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established following a report from the Montana Hospital Survey Committee that found Livingston was “one of the neediest cities in Montana from the standpoint of hospitalization.” Created by Governor Sam C. Ford in 1945, the Montana Hospital Survey Committee soon merged with the Commission on Hospital Care, a nationwide survey effort by the American Hospital Association to promote federal aid for hospital construction. Their work paid off in the form of the Hill-Burton Act, which created a generous 40% match program to help communities build modern medical facilities. Signed by President Harry S. Truman on August 13, 1946, the Hill-Burton Act transformed American healthcare, especially in rural states like Montana. Within the rush of post-World War II socio-economic development, hospital construction proved an especially popular modernization program at the national, state and local level. (See below for additional context on the Hill-Burton Act).

In the beginning, however, the community of Livingston intended to pay for its own hospital. The Livingston Community Hospital Association (LCHA) filed incorporation papers at the Park County Courthouse on December 26, 1946 to accept donations totaling \$350,000. After serious study, LCHA, “found that, even under present high costs of construction, it was possible to build a modern, fire-proof, 60-bed hospital for [that] amount of money.” (*LE*, 12-26-1946). The proposed hospital was met with “enthusiastic approval” from the Livingston community, a sentiment reflected by Lester E. Swanson, president of the Chamber of Commerce. “Today’s prospects for a modern hospital in the community look good,” he commented in late December:

Public-spirited individuals have laid the groundwork. Now all that is needed to make it a certainty is the whole-hearted cooperation of all in the community. This is certainly one project on which we all can work together. Sickness plays no favorites. It strikes everyone. Our pride in the proposed institution when it is finished will be all the greater if it is not the work of any one group or individual, but the result of the effort of everyone. (*LE*, 12-27-1946).

LCHA received its first donation on December 27, 1946, and the hospital campaign moved quickly through early 1947. The Board elected its first officers, with Ted Stump continuing on as president, formed committees for site selection, publicity, finances and special gifts, and elected Chan Libby, an army veteran with ample fundraising experience, as campaign chairman. They also announced that the hospital would be named Livingston Memorial Hospital in honor of the thirty-seven veterans from Park County killed during World War II. LCHA even managed to get an architectural drawing of their proposed hospital. Published in the *Enterprise* on April 17, 1947, the drawing depicts an imposing four-story, T-shaped structure with a streamlined Art Moderne entrance. Presumably provided by Cushing & Terrell, the eventual architects of Livingston Memorial, this design shows absolutely no resemblance to the one-story, Modern style hospital that opened in 1955.

Site selection for the proposed hospital also proceeded rapidly. Just days after incorporating, LCHA was already considering seven potential sites, and by March 1947 that number had grown to “a dozen or more.” Then, in late April, the *Enterprise* announced selection of a site at the southwest edge of town. Twenty-three lots in Block 29 of the Park Addition were generously donated by Ed Fleming and Jack Rydall, while the remaining nine lots were obtained through “cash and trade negotiations.” (*LE*, 4-24-1947). The Park Addition had an interesting history. Crawford Livingston, a Minneapolis businessman with ties to the Northern Pacific Railroad, purchased much of the property surrounding the original plat of Livingston in September 1882. This speculative real estate was quickly platted as the Minnesota, Palace and Park Additions, and eventually came under the ownership of the Livingston Townsite Co. While many of the lots in the Park Addition were sold for residential development, lots in the southwest corner—where Block 29 is located—were more difficult to move. It seems the Livingston Townsite Co. went under during the Great Depression, with their remaining lots (including most of Block 29 ) turned over to Park County in 1936. The County was able to sell most of these lots as economic conditions

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improved, but they remained largely undeveloped through World War II. As such, Block 29 in the Park Addition was undeveloped space at the edge of town: a perfect site for the future Livingston Memorial Hospital.

A final, and vitally significant, component of the early planning process was selecting a professional agency to manage the hospital when it opened. This responsibility fell to the Lutheran Hospitals and Homes Society of America (LHHS), who signed a lease agreement to manage the hospital for fifteen years on March 13, 1947. Based in Fargo, North Dakota, LHHS was incorporated as a non-profit organization in 1938, but had roots in the earlier Evangelical Lutheran Good Samaritan Society. LHHS started with seven hospitals in North and South Dakota, but by 1947 they were managing approximately fifty institutions in ten Midwestern States. In Montana, LHHS would eventually manage hospitals in Forsyth, Red Lodge, Scobey, Terry, Baker, Choteau, Harlowton, Big Timber, and Livingston. The lease between LHHS and LCHA included the following provisions, which would dictate operations at Livingston Memorial for years to come:

1. The hospital structure and equipment will cost no less than \$300,000.
2. LHHS will assist with the planning and supervision of hospital construction.
3. Gifts will remain the property of the LCHA.
4. LHHS will provide \$5,000 worth of equipment for the opening.
5. All deficits associated with hospital operation and maintenance will be obligated to LHHS.
6. The hospital will be open to all without regard to race, color or creed upon the recommendation of a qualified physician. This requirement was waived in emergencies.
7. Any physician or surgeon with a degree from an accredited college and Montana license could practice at the hospital.
8. The hospital will comply with standards set by the American Medical Association and the American Hospital Association.
9. Rates will be on par with those in other Montana hospitals. (*LE*, 3-14-1947).

With a site, managing agency and preliminary architectural drawing in place by May 1947, it seemed possible construction of Livingston Memorial Hospital might start in a matter of months. Unfortunately, LCHA ran into fundraising difficulties. It was not so much a lack of community support, as it was an issue of rising construction costs. By 1948, it was becoming increasingly clear \$350,000—the original fundraising goal set by LCHA—would not cover the size of hospital needed in Livingston. And Livingston, with a large population of high-risk railroad workers could not, in good conscience, downsize its hospital plans. This was especially true after LCHA agreed to reserve ten hospital beds for Northern Pacific employees. Left with an increasingly expensive hospital to build, LCHA turned to federal aid under the recently passed Hill-Burton Act. Participation in this program would allow LCHA to leverage local funds for the construction of a hospital that would actually meet community needs. Ultimately, this local-federal partnership produced a 52-bed hospital at a cost of just under \$700,000. Of this total, approximately \$560,000 would go to construction contracts, \$75,000 to equipment, \$56,000 to architect fees, \$480 to site survey, \$1,500 to consulting fees, and \$1,400 to sidewalks.

(Sources: *Livingston Enterprise*, 12-26-1946, 12-27-1946, 1-3-1947, 1-4-1947, 1-7-1947, 2-6-1947, 2-20-1947, 3-6-1947, 3-7-1947, 3-14-1947, 3-29-1947, 4-17-1947, 4-24-1947 and 1-11-1954; *Livingston City Directory*, 1946; Land Patents, 3-578 and 3-579; Deeds, 1-199, 2-170, 2-172, 2-174, 65-243, 65-244, 67-254, 72-166, 77-132, 77-133, 77-134, 77-149 and 77-193; Finding Aid, "Banner Health System Photograph Collection")

A Federal-Aid Hospital for Livingston

The use of Hill-Burton funds for Livingston Memorial Hospital meant construction depended on bureaucratic processes at the federal and state level, but waiting a few years was certainly preferable to



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building an undersized hospital, or worse yet, no hospital at all. Plans for Livingston Memorial Hospital were approved by the U.S. Health Service by early 1949, but construction would not begin for another three years. The delay came because Livingston Memorial Hospital was the largest Hill-Burton project yet undertaken in Montana, and there was difficulty securing the necessary funds at both the federal and local level. In early 1950, for instance, the *Great Falls Tribune* reported that the Livingston Hospital Community Association (LCHA) had successfully raised \$252,000, but still needed an addition \$88,000 to secure the federal aid. Moreover, the State Board of Health, who administered the Hill-Burton program in Montana, was initially hesitant to grant approval to such a large project, focusing instead on small hospitals in rural counties. It was not until January 20, 1951 that LCHA finally received approval from the State Board of Health to build a 52-bed, \$670,000 hospital. Construction was still dependent on federal appropriations, and Livingston would have to compete with four other communities for the appropriated funds, but it was it was the surest sign yet that Livingston Memorial Hospital was finally moving beyond the planning process.

In the meantime, LCHA continued to take raise funds, with pledged donations reaching nearly \$400,000 by the end of 1951. From this point forward the LCHA could focus on collecting pledges rather than getting new ones. It was fortunate that LCHA was reaching its fundraising goal, because in February 1952 the State Board of Health received word that Congress would fully fund Montana's proposed hospital construction budget. The way was clear for the Livingston project, which would take up two-thirds of the state's federal aid for hospital construction over the next fiscal biennium (1953-1955). It was finally time to call for construction bids on Livingston Memorial Hospital, but the original design, which dated back to 1947, proved too expensive. Undeterred, LCHA asked for revised plans from Cushing & Terrell. This revision retained the interior specifications (floor space and room number), but completely transformed the exterior of the building. Instead of multiple stories, the new hospital would be a one-story structure with multiple wings. Stylistically, the new design reflected the continued dominance and evolution of the Modern Movement in American architecture following World War II.

With Cushing & Terrell's revised plans approved at the state and federal level, LCHA issued a call for bids on March 22, 1952. "Letting of the contract," reflected the *Livingston Enterprise*, "will climax an endeavor which has been in progress here for several years, practically since the end of the war, and which involved two financial campaigns." (3-22-1952). The LCHA hoped to start construction in midsummer, but the opening of bids was pushed back to August 28<sup>th</sup>. Despite this delay, bid opening was undoubtedly a cause for celebration. LCHA board members were joined by the principal architects, Ralph Cushing and Everett Terrell, and Robert Munzenrider, Director of the State Division of Hospital Facilities, at the Park Hotel to open the sixteen bids submitted for construction of Livingston Memorial Hospital. The lowest bids for the general, mechanical and electrical contracts totaled \$551,017, a calculation that left everyone "highly elated," because it was \$7,000 under project estimates. All contracts went to Montana-based companies with the Roy E. Thompson Construction Co. of Billings securing the general contract, the Reber Plumbing and Heating Company of Helena the mechanical contract, and C. P. Electric, Inc. of Livingston the electrical contract. Finalized contracts still needed to be approved by the State Board of Health and the U.S. Heath Service, but LCHA expected to break ground on Livingston's new hospital in just a matter of weeks, with the entire project completed in 400 days.

The groundbreaking ceremony for Livingston Memorial Hospital on September 17, 1952 marked the culmination of six years of hard work with little reward for LCHA. As one speaker noted, "Although everyone connected with the hospital project at times had doubts if the plan would ever be successful, [fortunately] these doubts did not all come at the same time...and the goal was reached." The ceremony also revealed the significance of the new hospital to the community and the impact of the Hill-Burton Act in Montana. Governor John W. Bonner gave the opening remarks and "turned the first shovel...to inaugurate excavation operations." Bonner was followed by Wesley A. D'Ewart, a republican

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businessman from Park County who represented Montana's 2<sup>nd</sup> District in the U.S. House of Representatives. His remarks showed the bipartisan appeal of hospital construction under the Hill-Burton Act. "I supported this legislation," he stated, further explaining his belief that, "appropriations for hospital construction are money well spent by the government." Livingston's Mayor, Dan Miles, discussed the "Necessity of Hospitals," in Montana's growing communities, while Dr. B. L. Pampel, a local physician, touched on the evolution of healthcare in Livingston and beyond. "Construction of the Memorial hospital," Pampel stated:

....marks an important milestone in the history of this county and the state of Montana...About 50 years ago, \$3,500 was raised here for a St. Luke's hospital, but since at that time people came to hospitals only to die, not to be treated, the venture was a failure. However, through the advance of medicine, at the present time life expectancy has increased from between 45 and 50 years to 65 and 70 years. (LE, 9-18-1952).

With an assist from the federal government, Livingston Memorial Hospital was finally under construction. Cushing & Terrell's Mid-Century Modern design, which was pictured alongside a front-page article on the groundbreaking ceremony in the *Livingston Enterprise*, was the perfect complement for this monumental milestone in the evolution of healthcare in Livingston. The design called for a one-story, multi-wing structure of blond brick with contrasting red brick in the window bands that wrapped around much of the structure. In plan, the hospital would have a main wing running across the north corner of the block, a single northeast entrance wing off S. 13<sup>th</sup> Street, and two rear wings extending to the southwest. Each wing was characterized by a hospital function: the administrative corridor was in the north entrance wing; the pediatric corridor and surgery corridor were at the southwest and northeast ends of the main wing, respectively; the nursing corridor was in the south rear wing; and the maternity corridor was in the north rear wing. In accordance with its Modern aesthetic, the design offered few architectural flourishes with two exceptions: a diagonally-oriented canopy at the main entrance (since removed) and a detached, downward sloping roof over the surgery corridor. Within these wings, would be 52 hospital beds arranged in single, double and quadrupled rooms, and a nursery with 19 bassinets. Overall, the hospital's design was well received. "Cushing and Terrell is a fine, reliable firm," said Governor Bonner at the groundbreaking ceremony, and, "...upon completion, the Livingston Memorial Hospital [will] be one of the best and most modern hospitals of its size in the state." (LE, 9-18-1952; GFT, 9-18-1952).

Construction of Livingston Memorial Hospital moved forward rapidly in 1953, with the general contract 75% complete by December, but fundraising issues plagued the project over the following year. On January 11, 1954, the *Enterprise* reported that over \$122,000 in pledged donations remained unpaid to LCHA. "We must collect these pledges almost 100% if we are to finish the hospital this summer as planned," explained an LCHA official. In order to encourage (or shame) community members into paying up, LCHA published lists of outstanding pledges in the *Enterprise*. Payments trickled in, but not fast enough to meet the hospital's projected opening in summer of 1954. Even with the building complete and the equipment ordered at the start of 1955, LCHA struggled to open the hospital. They were still \$24,000 short, but also needed revenue to cover mounting maintenance and utility costs. On January 6, 1955, LCHA held a fateful meeting in the basement of the Elk's Club. About fifty members (anyone who donated \$25 or more) voted unanimously to open the hospital as soon as possible. The formal dedication was set for February 19, 1955.

(Sources: *Livingston Enterprise*, 2-20-1952, 3-22-1952, 8-27-1952, 8-29-1952, 9-12-1952, 9-18-1952, 1-11-1954, 1-18-1954, 1-5-1955 and 1-7-1955; *Great Falls Tribune*, 4-17-1949, 1-27-1950, 2-1-1952, 2-20-1952 and 9-18-1952; *Kalispell Daily Inter Lake*, 1-21-1951; Cushing & Terrell, Architectural Drawings, 7-7-1952).

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### Livingston Memorial Hospital Opens its Doors

Livingston Memorial Hospital was officially dedicated with great fanfare on February 19, 1955. It was a day nine years in the making for the entire community, but especially the Livingston Community Hospital Association (LCHA). Before anyone could celebrate, however, there was work to be done: hire staff, assemble furniture, mark linens, stock the gift shop and, most importantly, raise the remaining funds. To benefit the hospital, Livingston held its first annual charity ball on February 18<sup>th</sup> at the Elks Club. Ticket prices were set at an expensive \$25 per couple, but attendees were treated with the Turner Brothers Orchestra from Billings and the knowledge that their money was going to a good cause. Leading the volunteer effort to get the hospital ready was Edith King and Anne Panzner, officers of the Livingston Memorial Hospital League. At a meeting on January 31<sup>st</sup>, the League formed committees to make sterilization bags, wash and put away dishes, mark linens and ready the gift shop. Over the next month, the *Livingston Enterprise* documented their progress, noting that as the opening approached, "some of the women...have drafted their husbands to assist during the evenings." When male volunteers were called on specifically to assemble hospital furniture, they were instructed to bring their own screwdriver. A final contribution of the League was the donation of a silver cup to the first baby born at the Livingston Memorial Hospital along with a \$25 savings bond for the mother. The gift was awarded to Mrs. Robert Barnhart, who delivered a baby boy on March 1, 1955.

Opening Livingston Memorial Hospital was a women-led effort, and so too was its early operation. Job interviews were held in mid-February under Howard Place, regional director of the Lutheran Hospital and Homes Society (LHHS), and Miss Elinor Griffin, Livingston Memorial's newly-appointed superintendent. Originally from Maine, Griffin studied at New England Baptist Hospital and Denver University, and held supervisory positions at hospitals in Denver and Red Lodge, Montana before landing at Livingston Memorial. Staffing the hospital required filling several positions: regular nurses, practical nurses, nurses' aids, laboratory and x-ray technicians, maids, laundresses, janitors, bookkeepers, kitchen staff and an engineer. Of the thirty-four staffers hired in advance of the hospital's opening, all were women. Not surprisingly, three-fourths of the nursing staff transferred from the old Lott Hospital, which converted into a nursing home after its patients were transferred to Livingston Memorial. These women worked for each other and the community, but also with the male physicians practicing at Livingston Memorial. In accordance with LHHS policy, the new hospital was open to any physician with a license to practice in Montana and a degree from an accredited medical school. Doctors practicing in Livingston at the time included those at the old Park Hospital (Alfred M. Lueck, John A. Pearson, Lindsay M. Baskett and Thomas R. Clemons) and the Livingston Clinic (W. E. Harris, R. E. Walker and G. J. Moffitt), as well as Yokichi Itoh, an independent physician and surgeon. Dr. George A. Townsend, who gained fame during his long tenure at Chico Hot Springs, was Livingston Memorial's first Chief of Staff.

With everything nearly in place, Livingston Memorial Hospital was formally dedicated at 2:00 pm on Saturday, February 19, 1955. The speakers' lectern stood at the center of the hospital with rows of folding chairs extending down each corridor. Just like at the groundbreaking ceremony held two-and-a-half years earlier, Montana's governor was the featured speaker. Governor J. Hugo Aronson, who replaced John W. Bonner in 1953, told the crowd of approximately 400 attendees:

Livingston is fast moving forward from its position as a one-industry [railroad] town and as result can look with confidence to the future...What has all this to do with a hospital? A hospital must have a sound economic base. It is dependent upon the future of Livingston, and on the faith and determination of the people. (*LE*, 2-21-1955).

Aronson was followed by a list of other dignitaries, including Theodore E. Stump (president of LCHA), Fred R. Knautz (director of the LHHS) and Dr. G. D. Carlyle (executive director of the State Board of

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Health), who told the crowd to, “support this hospital by using it.” After the formal dedication, hundreds more community members turned up for an open house with refreshments served by the women and wives of the hospital board of trustees. What they found was a, “modern new institution, fully equipped, and almost ready to be opened to the public.” (LE, 2-21-1955). It would take another few days to ready the hospital for patients, with the official opening scheduled for February 28<sup>th</sup>.

Among the first patients to arrive were fifteen individuals transferred by ambulance from the Lott Hospital. Other “firsts” included two scheduled surgery patients, a logger who injured his leg on the job, and Mrs. Barnhart and her new baby boy. According to Supervisor Griffin, “The patient at Memorial hospital will have the best of everything, and the nurse will be equipped to render the best possible treatment.” (LE, 2-8-1955). She was particularly pleased with the facility’s equipment, which filled the hospital’s working spaces: a laboratory, radiographic room and emergency room at the back of the administrative corridor, a delivery room, labor room and two operating rooms in the surgery corridor, and a nursery in the maternity corridor. Between these primary spaces were restrooms, locker rooms for nurses and doctors, and plenty of storage for medical supplies. Near the main entrance in the administrative corridor was the hospital lobby and gift shop, alongside the superintendent’s office, business office, and a dictation room. The main nurses’ station and the service kitchen were situated near the center of the hospital, with secondary nurses’ located in the pediatric, maternity and nursing corridors. Patient rooms were arranged along these corridors, with a special playroom for children at the end of the pediatric corridor. When it opened, Livingston Memorial charged the following rates for an overnight stay: \$9.00 for a four-bed ward, \$11.00 for a two-bed room, \$12.50 for a private room, and \$15.00 for a private room with a bath. Outside of critical cases, patients could accept visitors between 9:00 am and 11:00 pm.

With opening of Livingston Memorial, the call for community pride and public-spiritedness at the beginning of the hospital campaign in 1946 was finally answered. Livingston Memorial Hospital was truly a community institution—a hospital built by the people of Livingston in the service of their fellow citizens.

(Sources: *Livingston Enterprise*, 1-4-1955, 1-5-1955, 1-7-1955, 2-1-1955, 2-8-1955, 2-10-1955, 2-16-1955, 2-21-1955, 2-24-1955, 3-1-1955 and 3-2-1955; Cushing & Terrell, Architectural Drawings, 7-7-1952).

Livingston Memorial Hospital Evolves

Livingston Memorial Hospital operated without much incident through the late 1950s and the 1960s. After getting the hospital up and running, Elinor Griffin left the superintendent position. She was followed by Milada Botten and Louise E. Cooper, who would run the hospital for over a decade. In addition to staff changes, there were also equipment upgrades. In 1957, for instance, the Livingston Community Hospital Association (LCHA) purchased new X-ray equipment with a \$13,200 grant from the Ford Foundation. Overall, however, the hospital that opened in 1955 met community needs until the early 1970s. At this time new hospital standards established by the State of Montana, as well as concerns about patient comfort, necessitated a remodeling project. Under the leadership of Walter Peterson, LCHA undertook its first major fundraising effort in several years with a goal to raise \$300,000 toward a phased remodeling project. Plans were provided by Berg-Grabow & Partners of Bozeman in 1972, and the fundraising campaign kicked off in April 1973. A well-attended “Champagne Ball” held during National Hospital Week on May 12<sup>th</sup> marked a highlight of the early campaign. By October 1973, donations totaled \$40,000 and LCHA put out a call for construction bids. The remodeling project proceeded slowly as money came in, with a priority on meeting statewide licensing standards. Lowest on the priority list was installing air-conditioning in the administrative offices. Edward L. Austin, Hospital Administrator during much of the 1970s oversaw this important modernization effort.

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The close of the 1970s was marked by conflict at Livingston Memorial Hospital. In April 1979, twenty registered nurses set up a picket line in front of the hospital—initiating the first strike of registered nurses in Montana history. While there were about “200 issues” at the onset of the strike, the fact that Livingston nurses were paid the lowest wages in the state stood at the heart of the conflict. The labor dispute was eventually resolved with federal mediation, but the relationship between LCHA and the Lutheran Homes and Hospitals Society of America (LHHS), the hospital’s longtime managing agency, was strained beyond repair. Conflict arose in the aftermath of the nurses’ strike, when LHHS proposed a steep rate hike in patient fees to cover higher wages. LCHA pushed back, claiming the fees were too high, and formed a committee to explore finding another managing agency. This action caused LHHS to forfeit their contract, with Arthur Brown, the hospital’s new administrator, accepting their letter of resignation in August 1979. While LCHA admitted they were unlikely to “get another financial agreement as attractive as the one it has with LHHS,” it was also felt that, “hospital management should improve.” (*LE*, 8-8-1979). Moving forward, LCHA would retain more control over their hospital, with the managing agency serving less as an administrator and more as a consultant. The Danmore Company and American Health Group International, Inc., both of Washington, served this role in the 1980s.

Richard “Charlie” Brown took over the administrator position at Livingston Memorial Hospital in 1985, a post he would hold for the next seventeen years. Along with Dr. Richard LeBlond, president of the Livingston Memorial Hospital Board, he would oversee the hospital’s most significant renovation. Planning for this project began in the spring of 1986, when the owners of a modular unit the hospital was using raised their rental fees. Fortunately, the hospital was in good financial position after netting an impressive income of \$221,695 during the 1985-1986 fiscal year. The hospital also had very little debt, which was a double-edged sword according to LeBlond:

The reason we have no debt is that nothing’s been done to this hospital in 30 years. We cannot undertake a major renovation project without assuming debt. But we cannot remain competitive if we do not undertake such projects as this. (*LE*, 1-28-1987).

In early 1987, the Hospital Board moved forward with renovation plans by hiring Hospital Development, Inc. to prepare a feasibility study. They also retained the original architectural firm (now named CTA) to draw up preliminary plans for the renovation project. Bids for the multi-phase project were sent out in late September and contracts were awarded on October 1<sup>st</sup>. The low bid of \$697,655.00 for the general contract came from the Taylor Construction Co. of Bozeman, Montana. Among the changes called for under the renovation were: remodeling the medical wing, removing the four-bed wards, adding a wing with four private rooms, installing showers and toilets in patient rooms, re-roofing the hospital, and upgrading electrical, HVAC and safety systems.

The renovation project started in 1987 was the last significant change to the original hospital. It expanded the original medical wing (or surgical corridor) by filling in the open space between it and the north administrative wing. This new space was occupied by intensive care and emergency services. The new wing with four private rooms bumped out into the rear courtyard between the maternity and nursing wings. Perhaps the greatest change, however, was how the renovation essentially shifted the main entrance to the north side of the hospital. The original entrance at north end of the administrative wing remained open, but its stylish, diagonally-oriented canopy was removed. Despite these significant alterations, Livingston Memorial Hospital retained its Mid-Century Modern aesthetic. Selection of the original architectural firm (Cushing & Terrell / CTA) ensured the continuity of design. While exterior changes to the original building were limited, there were other interior alterations. A remodeling project in 2004, for instance, created more room for outpatient services and swing bed patients. Changes to the site have also been relatively minimal. A gable-roofed building was erected at the northwest corner of the block in c. 2004. There is also a small, frame utility building at the southeast corner of the hospital and a

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small, frame groundskeepers shed at the south corner of the block. A series of modular units added to the nursing and maternity wings were removed when the hospital was abandoned in 2015.

Livingston Memorial Hospital also experienced a significant growth in services in the 1980s and 1990s, which expanded its reach into facilities across Livingston. Hospice and homecare services were added in the late 1980s. Livingston Memorial also began purchasing local doctor's clinics in the late 1990s, including Park Clinic, which moved from the old Park Hospital to the new Edgewater Complex on River Street in 1973, and the Rowe Clinic on S. Main Street. Physicians working in these clinics were added as permanent hospital staff. Finally, the hospital helped establish Community Health Partners in 1997, a separate non-profit organization that could better serve Livingston's growing uninsured (or under-insured) population. Expansion was good for the community, but Livingston Memorial Hospital became overextended. The hospital was losing money by 1999, and was \$2 million in debt by 2002. Changes needed to be made if Livingston's community hospital was to remain open.

(Sources: *Livingston Enterprise*, 1-26-1973, 2-14-1973, 2-27-1973, 3-14-1973, 5-14-1973, 10-4-1973, 8-8-1979, 8-17-1979, 9-14-1979, 9-21-1979, 1-28-1987, 7-30-1987, 8-27-1987 and 10-1-1987; *Great Falls Tribune*, 8-22-1957, 4-25-1979, 6-24-1979, 8-13-1979 and 6-23-2002; Livingston City Directories; Livingston HealthCare Timeline; *History of Park County*)

Livingston HealthCare

The survival of Livingston Memorial Hospital was critical to Livingston and Park County. Not only did the hospital provide essential healthcare, but it was the county's largest employer with a staff of over 250. The first attempt to keep Livingston Memorial Hospital afloat came in 2001, when it received federal designation as a critical access hospital (CAH). Created in 1997, the CAH program aims to "reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities," through a system of cost-based Medicare reimbursement. (RHIhub Website). The hospital also took a symbolic step in 2001: changing its name from Livingston Memorial Hospital, which was lovely but outdated, to the more contemporary Livingston HealthCare. Unfortunately, these measures proved insufficient and Livingston HealthCare was forced to look for outside assistance. In May 2002, Livingston HealthCare signed an agreement with Billings Clinic, a non-profit healthcare group based in Billings, Montana, to manage the hospital for at least one year. The decision was fortuitous. After five years under the management agreement, Billings Clinic and Livingston HealthCare underwent an official merger. There were many benefits to merging with Billings Clinic, but by far the greatest was how the larger organization could assist Livingston HealthCare construct a new, multi-million dollar medical complex. Opened in 1955, the old hospital was still, "receiving high marks for customer satisfaction but...was losing business to more modern facilities with easier access." In short, Livingston Memorial was too old and too small to meet community needs in today's competitive healthcare market.

Plans for a new Livingston HealthCare facility were already underway before the merger with Billings Clinic. A 29-acre parcel was donated for a new hospital by Wayne and Rosalene Peterson in 1998, but the location was unworkable. This land was later sold with the profits going toward a new hospital. In 2003, Livingston HealthCare hired a consulting firm to study the community's future medical needs. It was not until 2007, however, that the new hospital appeared within reach. In addition to the merger with Billings Clinic, this was the year that Ted and Georgeann Watson donated a 20-acre parcel on the east side of town that was, importantly, outside the Yellowstone River's 500-year flood plain. Over the next several years, Livingston HealthCare worked hard to secure a new hospital for the Livingston community. They hired Erdman Architects, a nationally-renowned firm specializing in healthcare facilities, to prepare architectural plans and started looking for funding. When USDA Rural Development came through with \$39 million in loans in 2012, the project took a giant leap forward. Ground was broken in November 2013 and the new, \$43.5 million, 25-bed facility was officially dedicated on October 10, 2015. Recently named

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one of the top 20 critical access hospitals in the nation, Livingston HealthCare successfully meets all of the community's medical needs under one roof.

One attendee at the dedication ceremony of the new hospital proclaimed it, "the biggest thing to happen in Livingston since the railroad came to town in the 1880s." (LE 10-22-2015). It is easy to imagine the crowd gathered sixty years earlier at the dedication of Livingston Memorial Hospital experiencing a similar feeling of awe. After all, the two hospitals have much in common. Both took almost a decade to materialize, but were eventual brought to fruition by a combination of local effort and generous federal funding. More significantly, Livingston Memorial Hospital and its successor, Livingston HealthCare, are forever intertwined with some of the most significant aspects of community life: illness and death, as well as healing and birth. More than just buildings, hospitals are true community institutions that touch the lives of nearly everyone living within their reach.

(Sources: *Great Falls Tribune*, 5-26-2002, 6-23-2002, 1-28-2006, and 5-7-2007; *Montana Standard*, 1-29-2007; *Billings Gazette*, 10-18-2015; Livingston HealthCare Timeline; Livingston HealthCare Website; RHlhub Website; USDA Rural Services)

Livingston Memorial Hospital Breaths New Life

On October 27, 2015—the day the new Livingston HealthCare facility opened to patients—hospital staff placed, "large signs outside the newly-emptied former LHC building to direct people to the new hospital." (LE 10-22-2015). Livingston Memorial Hospital, a building continuously occupied by staff, patients and visitors for sixty years, now stood empty. A recent proposal to rehabilitate the former hospital into affordable housing units, however, promises to revive the abandoned structure. The hospital will soon be acquired by Bluebunch Flats, LLLP, whose General Partner is a subsidiary of Homeword, a Missoula, Montana-based non-profit focused on affordable housing and sustainable communities. In November 2017, Homeword was allocated over \$5 million in grants from the Montana Board of Housing to convert Livingston Memorial Hospital into thirty-four rental units, with a mix of studio, one-bedroom and two-bedroom apartments. Named Bluebunch Flats, in honor of Montana's state grass, the apartments will be aimed at residents earning up to 40% to 60% of Livingston's median income. Homeword has partnered with the municipal and city governments, as well as local non-profits like Community Health Partners and HRDC, to ensure the building will be a community asset. In addition to state funding, Homeword also hopes to utilize the federal Historic Preservation Tax Credit to assist with the rehabilitation of the former hospital. NE45 Architecture of Bozeman, Montana is responsible for the historically-sensitive design. The \$7 million project will allow Livingston Memorial Hospital to again serve the community of Livingston—this time as much-needed affordable housing.

(Sources: *Livingston Enterprise*, 10-22-2015 and 7-14-2017; *Bozeman Daily Chronicle*, 11-22-2017).

**CRITERION A: The Hill Burton Act in Montana**

Hospital Development in the Postwar World War II Era: The Hill-Burton Act of 1946

America emerged from World War II as a global superpower ready to build the modern world. A decade of economic depression flanked by two deadly wars left the nation's built landscape worn and outdated, and Americans were eager to move forward. The federal government provided an unprecedented boost in socio-economic development with the GI Bill, a comprehensive benefit package that offered veterans free college tuition, guaranteed mortgages, unemployment compensation, and low-interest business loans. The Department of Veteran's Affairs backed approximately 2.5 million home loans between 1944 and 1952, driving new home construction and suburban development to record-setting heights. Infrastructure and social services were also targeted for modernization by the federal government with the Federal-Aid Highway Act of 1944 and the Hospital Survey and Construction Act (or Hill-Burton Act) of 1946. The

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former laid the groundwork for America's ambitious system of interstate highways, while the Hill-Burton Act would have a transformative impact on the nation's healthcare system by providing federal funds for hospital construction. Between 1946 and 1968, the federal government aided construction of 9,200 new medical facilities in the United States under the Hill-Burton Act. Livingston Memorial Hospital, which opened in 1955, was among this group of federally-funded postwar hospitals.

Passage of the Hill-Burton Act in 1946 was the result of a decades-long debate over how to provide Americans with healthcare. By the early 20<sup>th</sup> century most Americans agreed medical care vastly improved their quality of life, but debate over how to distribute and pay for this essential, but increasingly expensive, service was widespread. The dual system of private medical care for "respectable" citizens and public care for the indigent still reigned supreme, although (as discussed above) hospital care was becoming increasingly popular. One unfortunate side effect of the transition to hospitals was a dramatic rise in healthcare costs for both practitioners and patients. From this point forward, "operating costs now needed to be covered directly from patient fees," explains Joseph S. Ross, an Associate Professor at the Yale School of Medicine, in an article examining healthcare in the early 20<sup>th</sup> century. (130). Ultimately, two means of addressing rising medical costs emerged from the debate: compulsory health insurance and government aid for hospital construction. While not mutually exclusive, hospitals eventual overcame insurance as the federal government's preferred method for addressing the healthcare needs of all Americans.

Health insurance first appeared in the United States as either employer-based or as a policy option offered by private insurance companies, but proposed legislation authorizing "compulsory, state-run health insurance" was not far behind. The first such effort, dubbed the "Standard Bill," was drafted by the American Association for Labor Legislation (AALL) and the American Medical Association (AMA) in 1915. The Standard Bill was lost during the upheaval of World War I and the AMA soon dropped its support for compulsory health insurance, but efforts to understand the economics of healthcare were reignited with the formation of the Committee on the Costs of Medical Care (CCMC) in 1927. Funded by private philanthropic foundations, this independent group of healthcare experts went on to publish twenty-three major reports on the economic aspects of healthcare over a five year period. Their final report, published in 1932, offered four primary recommendations: (1) physician groups should provide medical care, (2) an insurance program should be developed to distribute costs, (3) funds for disease prevention should be increased, and (4) community agencies should coordinate medical services. Most physicians saw the CCMC report as a threat to their livelihood and the AMA panned its recommendations as "communist" and an, "incitement to revolution." This overwhelmingly negative response, as well as a focus on more fundamental relief, likely kept health insurance reform out of progressive New Deal legislation during the Great Depression.

Healthcare received renewed attention during World War II. Legislation authorizing universal health insurance (the Wagner-Murray-Dingell Bill) was introduced in 1943 and President Franklin D. Roosevelt included "the right to adequate medical care and the opportunity to achieve and enjoy good health," in his 1944 "economic bill of rights." Roosevelt's successor, President Harry S. Truman, brought even greater focus to healthcare reform. "There were two components of Truman's postwar vision for a national plan of healthcare," explains Gunnar Almgren, a Professor of Social Work at the University of Washington, in his recent book, *Healthcare as a Right of Citizenship*:

One was universal social insurance for healthcare, and the other entailed massive federal investments in the national health-care infrastructure—in particular, the nation's already antiquated and altogether inadequate hospital system. Until the mid-nineteenth century, the government's role in the funding of hospital construction was largely limited to serve the maritime industry, hospitals for soldiers and veterans, and, at the state level, asylums for the mentally ill. The county hospital system, such as it existed, was poorly funded,



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antiquated and not at all capable of absorbing the millions of Americans in need of hospital care who, with the greater availability of health insurance, would be able to afford it. (11-12).

Truman's policy was heavily influenced by the American Hospital Association (AHA). Anticipating the possibilities of postwar development, the AHA formed the Commission on Hospital Care in 1942 to survey the nation's current hospital facilities. Not surprisingly, the AHA found a pressing need for almost 200,000 most hospital beds, an expansion effort with an estimated \$1.8 billion price tag. (Starr, 349).

A federal program for hospital construction proved a winning proposal in postwar America. As Paul Starr explains in his Pulitzer Prize-winning book, *The Social Transformation of American Medicine*, hospital construction was popular in both liberal and conservative circles. It promised modern medical care to previously underserved communities, while also creating jobs in construction and healthcare. At least according to conservatives, it also provided "a morally acceptable alternative" to national compulsory health insurance. (Starr, 347-348; Almgren, 12). This push for a nation hospital construction program culminated in the Hospital Survey and Construction Act, which Truman signed into law on August 13, 1946. Popularly known as the Hill-Burton Act after its two primary sponsors, Alabama Senator Lister Hill and Ohio Senator Harold Burton, the legislation did weaken the universal health insurance movement, but liberal reformers also won two important concessions. Hospitals built with federal assistance could not discriminate based on "race, creed or color," and were required to provide, "a reasonable volume of hospital services to persons unable to pay." (Starr, 350). Unfortunately, these admirable provisions were undercut until the mid-1960s by a "separate but equal" exemption in the segregated South, and no definition or enforcement regarding patients with financial hardship. By far the most significant impact of the Bill, however, was the complete centralization of hospitals within the American healthcare system.

The long-term effects of the Hill-Burton Act on healthcare policy are debatable, but the immediate impact was widespread and overwhelmingly positive. Initially, the Hill-Burton Act provided \$2.3 million in funding for state survey and planning projects and \$75 million annually for five years to aid the construction (or expansion) on non-profit hospitals. Between 1946 and 1971, \$3.7 billion in federal funds aided the construction of 10,748 medical facilities, which also leveraged an estimated \$9.1 billion in investments at the local and state level. (Thomas, "Hill-Burton Act"). The impact was especially felt in rural areas and small towns, as documented by the *American Journal of Public Health* in 1956:

Of over a thousand new hospitals built with federal aid during this decade, over half are in communities of under 5,000 people and only about one in nine are in cities over 50,000...Several hundred Tinytowns thus have new hospitals; others still need them; still others should have hospital care through regional organization rather than inadequate local facilities. (1576-1577).

The focus on "tinytowns" benefited Montana and other rural states immensely. By 1956, Montana had received nearly \$3 million from the Hill-Burton Act, which aided in the construction or expansion of twenty-nine medical facilities, including Livingston Memorial Hospital. Still, as the above quote suggests, not every community was able to secure a new hospital. Federal funding was allocated to each state based on its population and per-capita income. This money was then passed through by the state to select communities based on need and the ability to provide matching funds. This system, according to Starr in *The Social Transformation of American Medicine*, was both redistribute and regressive. Nationally, the Hill-Burton Act leveled the playing field, because its allocation formula favored states with low per-capita incomes. It was less effective at the local level, with only relatively well-off communities able to the produce the matching funds required to secure federal aid for hospital construction projects. (Starr, 350). Even in Montana, a state with few sizable towns, requests for aid under the Hill-Burton Act regularly "exceeded available monies," leaving some locales behind in healthcare development. (1956, MT BOH, 35). Despite this lack of reach to the nation's neediest communities, the

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Hill-Burton Act still transformed healthcare by bringing modern medical facilities to thousands of “tinytowns” across America.

(Sources: *Healthcare as a Right of Citizenship*; “A Decade of Hill-Burton Hospital Funds;” “A Forgotten Landmark Study from 1932 by the Committee on the Cost of Medical Care;” “Montana State Board of Health, 1954-1956;” “The Committee on the Costs of Medical Care and the History of Health Insurance in the United States;” “Detailed Chronology of Social Insurance & Social Security;” Starr, Paul. *The Social Transformation of American Medicine*; Thomas, Karen Kruse. “Hill-Burton Act,” *Encyclopedia of Alabama*)

The Hill-Burton Act in Montana, 1946 - 1956

The State of Montana was eager to join the federal hospital construction program authorized by the Hill-Burton Act of 1946. Like the rest of the nation, Montana experienced a wave of socio-economic development following World War II that pushed modernization and suburban growth. Montana lost population during World War II to military service and high-paying manufacturing jobs on the West Coast, but rebounded quickly after the war resulting in a net population gain through the 1940s. By 1960, the population reached an all-time high of 674,767. With the exception of Butte (a historic mining community), much of this growth occurred in Montana’s cities. The population of Billings and Great Falls doubled between 1940 and 1960, while Helena, Bozeman and Missoula also grew steadily. Livingston saw a significant postwar jump in population from 6,642 in 1940 to 8,229 in 1960. As discussed above, new homes accounted for much of the nation’s new construction, but postwar Americans—who were, on average, becoming increasingly prosperous—also wanted modern retail centers, schools, churches, government buildings and hospitals. This postwar sentiment was perfectly captured by T. E. Stump, president of the Livingston Community Hospital Association, as he campaigned for donations in early 1947:

This does not mean that the people who have operated hospitals here in the past have not done a fine job. We believe that they have done a wonderful job, considering what they had to work with and the type of support which the community has given them. We also believe in progress, and that the time must inevitably come when that which has served in the past will not do in the future. It is for the future of Livingston, for an age when people demand and believe they are entitled to all the modern things medical and surgical science can provide, that we are building our new hospital. (LE, 2-6-1947).

Fortunately, Montana emerged from World War II with money to spend. In 1945, the State Legislature created the Montana Postwar Planning and Construction Commission, an agency charged with managing \$4.5 million in wartime surplus funds to be used for water conservation and state building needs. At the same time, Governor Sam C. Ford created a 23-member Montana Hospital Survey Committee to “survey Montana’s hospital and public health requirements for recommendation to national and state public health authorities.” (GFT, 5-24-1945). Led by Edwin Grafton, then president of the Montana Hospital Association, this effort was part of the Commission on Hospital Care, a national survey sponsored by the American Hospital Association. In general, the Montana Hospital Survey Committee found that the state had a high ratio of “bed facilities to population,” but the quality and spatial distribution of existing hospitals needed vast improvement. More specifically, the survey described Livingston as “one of two communities in the state which are severely ‘underhospitalized.’” (LE, 2-6-1947).

The Hill-Burton Act, signed by the President Truman on August 13, 1946, promised to address many of Montana’s hospital needs, and the Hospital Survey Committee was quick to recommend that the state participate in the new federal-aid program. With the State Legislature convening biennially, however, Montana would have to wait until 1947 to join the ambitious hospital construction plan outlined by the Hill-Burton Act. Under the federal program, participating states were required to comply with the

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following provisions: (1) designate a single state agency to administer the hospital construction program, (2) create a state advisory council, (3) survey current hospital facilities, (4) create a statewide hospital development plan, and (5) establish minimum standards for the maintenance and operation of federal-aid hospitals. Montana's enabling legislation, dubbed the State Hospital Survey and Construction Act, placed responsibility for Hill-Burton funding with the Division of Hospital Survey and Construction, a newly-created division of the State Board of Health, and created a government-appointed Hospital Advisory Commission. A second act, the State Licensing Law, set standards for all medical facilities in Montana.

The State's Division of Hospital Survey and Construction was staffed by a director (B. K. Kilbourne, M. D.), a consulting engineer (Robert J. Munzenrider), a consulting architect (Vincent H. Walsh), a consulting nurse (Marjorie Dumez, R. N.) and a senior stenographer (Alice L. Henry). Its first task was to transform the work of the Montana Hospital Survey Committee into a statewide plan for hospital construction. Because the Committee's data was already two years old, the Division completed a supplementary survey that revealed twenty-eight communities "contemplating" hospital construction at an estimated total cost of \$14 million. Approved by the U.S. Surgeon General on February 19, 1948, the statewide plan took preexisting community plans into consideration, but mostly stressed a hospital distribution model based on geography and demographics. The state was divided into six "intermediate areas" with a population between 25,000 and 100,000 and twenty-four "rural areas" with a population of under 25,000. Each area was then allocated a certain number of hospital beds, which were further divided among towns. Rural Area 18, for instance, was allocated 60 beds with a proposed 50-bed general hospital in Livingston and a 10-bed community clinic in nearby Big Timber. Intermediate Area 6 in contrast, required 334 beds according to the plan with 239 going to Butte, 75 to Anaconda and 10 each to Virginia City and Whitehall.

The Montana State Plan for Hospital Construction also added a hierarchy of need-based priorities to its spatial framework. Under this hierarchy, areas were assigned a priority level-based on the percentage of needs met (acceptable existing beds vs. needed beds). Eleven rural areas were placed in the highest priority category, with under 10% of their hospital needs met. This list included Rural Area 18 (Livingston-Big Timber), which was found to have zero "acceptable" hospital beds. By 1955, all eleven high-priority areas were addressed with new hospitals opened in Cut Bank (1949), Big Timber (1950), Malta, Choteau, Harlowton, Red Lodge and Culbertson (1951), Libby, Hot Springs and Scobey (1952), Plentywood (1953), Roundup (1954) and Livingston (1955). It is interesting to note that while Livingston was considered "severely underhospitalized" in 1945, it was the final community to receive a new hospital within the eleven high-priority districts. This was most likely due to its relatively large size (52 beds) and the associated construction costs (\$692,213.26). Livingston Memorial Hospital was well above the average size for Hill-Burton hospitals in Montana, which stood at about 24 beds in 1956. It was also twice as expensive to build as the second largest Hill-Burton hospital in Montana: the 46-bed Glacier County Memorial Hospital in Cut Bank. Livingston was willing to invest in its healthcare infrastructure after World War II, but it took the community several years to secure the \$416,000 needed to cover their share of hospital construction costs.

In its first decade alone, the Hill-Burton Act provided nearly \$3 million in federal aid to Montana. This money went toward the construction or expansion of twenty-nine medical facilities, with local communities pitching in another \$7.7 million in funding. By 1966, Hill-Burton funds aided 66 projects in 37 communities across Montana. In addition to its impact on healthcare, the Hill-Burton Act also left an important architectural legacy. Outside of one or two exceptions, Montana's Hill-Burton hospitals were shining examples of Mid-Century Modernism. Almost all are long, low (one-or two-story), flat-roofed brick structures with clean lines and minimal ornamentation. Rectilinear windows, often arranged in bands, light each story, while window-wall entrances are protected by flat canopies. In floorplan, the hospitals range in complexity from simple rectangular shapes to multiple wings. These modern designs

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sprang from the minds of Montana's leading architectural firms. J. G. Link, a firm with roots dating back to the 1890s in Montana, designed most early Hill-Burton hospitals, but it was the Billings-based firm, Cushing & Terrell, who received national recognition for the Carbon County Memorial Hospital in Red Lodge. Opened in September 1951, this building was named "Modern Hospital of the Month" by the Modern Hospital Publishing Co. in February 1952 for "excellence of design, functional planning, economy of construction and operation, and proper provision for hospital needs of the community." (1954, BOH, 119). Cushing & Terrell also provided the design for Livingston Memorial Hospital.

In summation, the Hill-Burton Act had a transformative impact on Montana's healthcare and built environment. It brought state-of-the-art medical facilities and Modern architecture to small towns across the state. As the largest and most expensive Hill-Burton hospital built statewide during the program's first decade, Livingston Memorial Hospital is an important physical reminder of the Hill-Burton Act's legacy in Montana.

(Sources: *Livingston Enterprise*, 2-6-1947; *Great Falls Tribune*, 5-24-1945; Montana State Board of Health Biennial Reports, 1945 – 1966; Montana State Plan for Hospital Construction, 1948; *Montana Post-World War II Architectural Survey and Inventory: Historical Context and Survey Report*)

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PROPERTY RECORDS

Land Patent. United States to Alfred Parker (W ½ NW ¼, Section 24, T2S, R9E, Park County, Montana). Park County Clerk & Recorder, Deed Book 2, Page 176. Recorded 9-21-1882. Patent 3-579 Issued 4-2-1884.

Land Patent. United States to Robert Thomas (Lots 1 and 2, Section 24, T2S, R9E, Park County, Montana). Park County Clerk & Recorder, Deed Book 2, Page 177. Recorded 9-21-1882. Patent 3-578 Issued 4-17-1884.

Deed. Robert Thomas to Columbus Beckwith (Lots 1 & 2, Section 24, T2S, R9E, Park County, Montana). Park County Clerk & Recorder, Deed Book 2, Page 170. Recorded 9-21-1882.

Deed. Alfred Parker to Columbus Beckwith (W½ NW¼, Section 24, T2S, R9E, Park County, Montana). Park County Clerk & Recorder, Deed Book 2, Page 172. Dated 7-5-1882. Recorded 9-21-1882.

Deed. Columbus E. Beckwith to Crawford Livingston (W ½ of the NW ¼ and lots 1 and 2, Section 24, T2S, R9E, Park County, Montana / “Park Addition”). Park County Clerk & Recorder, Deed Book 2, Page 174. Dated 7-6-1882. Recorded 9-21-1882.

Deed. Crawford Livingston to Livingston Land Company (W ½ NW ¼ and lots 1 and 2, Section 24, T2S, R9E, Park County, Montana). Park County Clerk & Recorder, Deed Book 1, Page 199. Dated 8-1-1887, Recorded 1-12-1888.

Deed. Lots Livingston Townsite Co. to Park County (Lots 1-2, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 65, Page 243. Recorded 2-13-1936.

Deed. Livingston Townsite Co. to Park County (Lots 7-29, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 65, Page 244. Recorded 2-13-1936.

Deed. Park County to Anna Bennett (Lots 1-2, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 67, Page 274. Recorded 3-15-1938.

Deed. Ann Bennett to Livingston Community Hospital Association (Lots 1-2, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 77, Page 193. Dated 4-3-1948. Recorded 5-7-1948.

Deed. Lots 30-32. Park County to Leslie H. Sodergren (Lots 30-32, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 72, Page 166. Recorded 6-13-1944.

Deed. Edward L. & Elizabeth E. Fleming and John M. & Marie G. Ryall to Livingston Community Hospital Association (Lots 7-24, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 77, Page 132. Dated 12-30-1947. Recorded 4-6-1948.



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Deed. Edward L. & Elizabeth E. Fleming and John M. & Marie G. Ryall to Livingston Community Hospital Association (Lots 25-29, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 77, Page 133. Dated 1-10-1948. Recorded 4-6-1948.

Deed. Leslie H. and Ethel M. Sodergren to Livingston Community Hospital Association (Lots 30-32, Block 29, Park Addition, Livingston Montana). Park County Clerk & Recorder, Deed Book 77, Page 134. Dated 2-23-1948. Recorded 4-6-1948.

Deed. Howard L. & Mildred J. Painter to Livingston Community Hospital Association (Lots 3-6, Block 29, Park Addition, Livingston, Montana). Park County Clerk & Recorder, Deed Book 77, Page 149. Dated 4-12-1948. Recorded 4-13-1948.

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**Previous documentation on file (NPS):**

- ☐ preliminary determination of individual listing (36 CFR 67) has been requested
- ☐ previously listed in the National Register
- ☐ previously determined eligible by the National Register
- ☐ designated a National Historic Landmark
- ☐ recorded by Historic American Buildings Survey # \_\_\_\_\_
- ☐ recorded by Historic American Engineering Record # \_\_\_\_\_
- ☐ recorded by Historic American Landscape Survey # \_\_\_\_\_

**Primary location of additional data:**

- ☒ State Historic Preservation Office
- ☐ Other State agency
- ☐ Federal agency
- ☐ Local government
- ☐ University
- ☐ Other
- Name of repository: \_\_\_\_\_

**Historic Resources Survey Number (if assigned):** \_\_\_\_\_

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**10. Geographical Data**

**Acreage of Property** 2.57

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Use either the UTM system or latitude/longitude coordinates

**Latitude/Longitude Coordinates**

Datum if other than WGS84: \_\_\_\_\_

(enter coordinates to 6 decimal places)

- |                       |                       |
|-----------------------|-----------------------|
| 1. Latitude: 45.64934 | Longitude: -110.57030 |
| 2. Latitude: 45.64992 | Longitude: -110.56924 |
| 3. Latitude: 45.64898 | Longitude: -110.56822 |
| 4. Latitude: 45.64842 | Longitude: -110.56923 |

**Verbal Boundary Description** (Describe the boundaries of the property.)

The property encompasses all of Block 29 of the Park Addition to the City of Livingston.

**Boundary Justification** (Explain why the boundaries were selected.) The boundary encompasses the historical property owned and maintained by the Livingston Memorial Hospital from the time the doors opened until the time the new hospital was opened and the Livingston Memorial Hospital doors closed for the last time as a health care facility.

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**11. Form Prepared By**

name/title: Jessie Nunn / Independent Consultant  
organization: \_\_\_\_\_  
street & number: 600 Meadowlark Lane  
city or town: Livingston state: Montana zip code: 59047  
e-mail [jessienunn@gmail.com](mailto:jessienunn@gmail.com)  
telephone: 406-208-8727  
date: July 1, 2017

with assistance from:

name/title: Julie M. Stiteler, Housing Project Manager  
organization: Homeword, Inc.  
street & number: 1535 Liberty Lane, Suite 116A  
city or town: Livingston state: MT zip code: 59047  
e-mail [julie@homeword.org](mailto:julie@homeword.org)  
telephone: 406-532-4663, ext. 19  
date: 12/20/2017

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## Additional Documentation

Submit the following items with the completed form:

- **Maps:** A USGS map or equivalent (7.5 or 15 minute series) indicating the property's location.
- **Sketch map** for historic districts and properties having large acreage or numerous resources. Key all photographs to this map.
- **Additional items:** (Check with the SHPO, TPO, or FPO for any additional items.)

## Photographs

Submit clear and descriptive photographs. The size of each image must be 1600x1200 pixels (minimum), 3000x2000 preferred, at 300 ppi (pixels per inch) or larger. Each photograph must be numbered and that number must correspond to the photograph number on the photo log. For simplicity, the name of the photographer, photo date, etc. may be listed once on the photograph log and doesn't need to be labeled on every photograph.

## Photo Log: all photos

Name of Property: Livingston Memorial Hospital

City or Vicinity: Livingston

County: Park

State: MT

Photographer: Jessie Nunn

Date Photographed: Exterior photos taken October 28, 2017. Interior photos taken on December 15, 2017.

Description of Photograph(s) and number, include description of view indicating direction of camera:

1 of \_\_\_\_.

See Below

**Paperwork Reduction Act Statement:** This information is being collected for applications to the National Register of Historic Places to nominate properties for listing or determine eligibility for listing, to list properties, and to amend existing listings. Response to this request is required to obtain a benefit in accordance with the National Historic Preservation Act, as amended (16 U.S.C. 460 et seq.).

**Estimated Burden Statement:** Public reporting burden for this form is estimated to average 100 hours per response including time for reviewing instructions, gathering and maintaining data, and completing and reviewing the form. Direct comments regarding this burden estimate or any aspect of this form to the Office of Planning and Performance Management, U.S. Dept. of the Interior, 1849 C. Street, NW, Washington, DC.





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**LIVINGSTON MEMORIAL HOSPITAL - SITE PLAN**

**1 - Utility Building (Home Oxygen)**



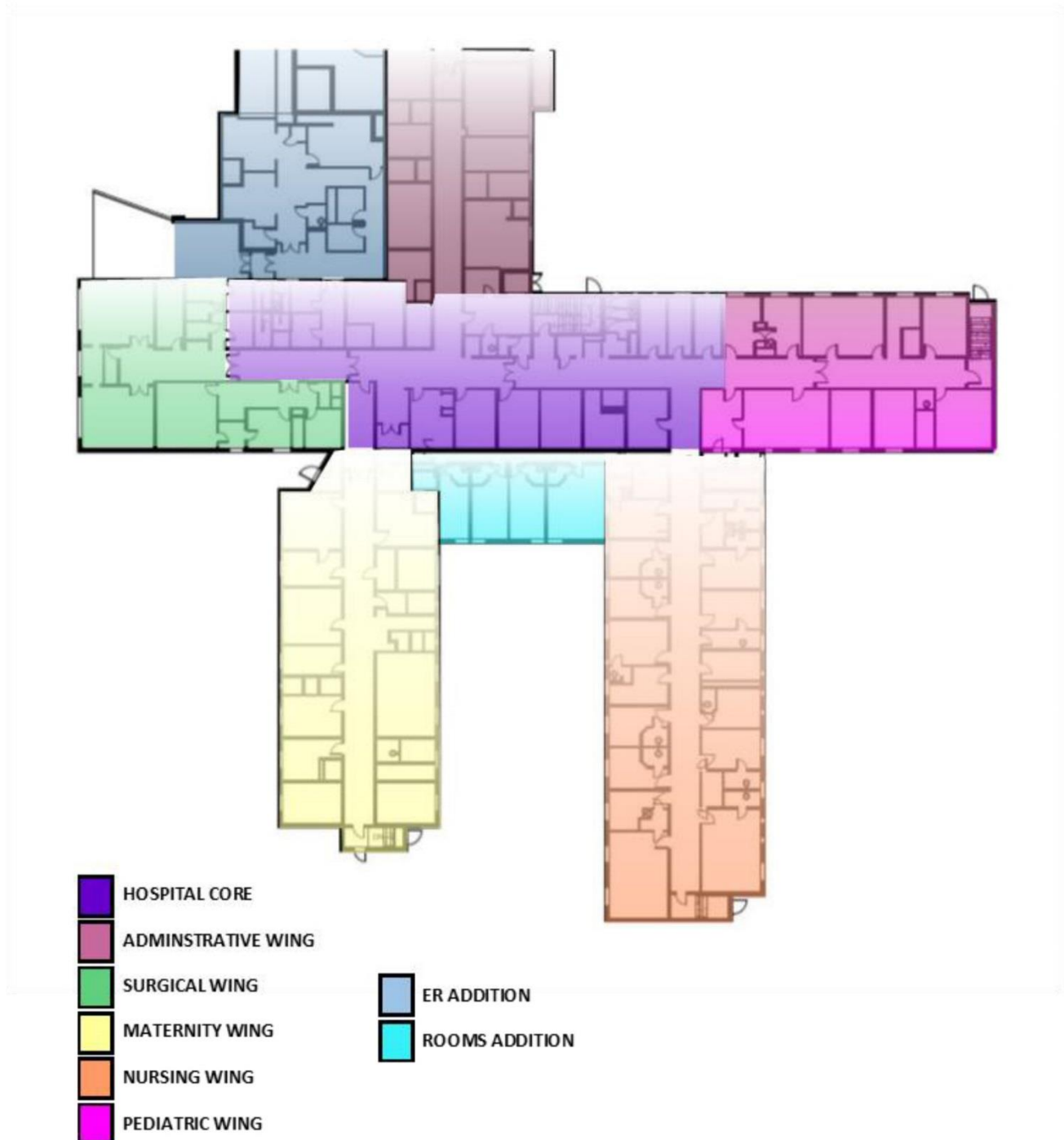
**- Modular Units (non-extant)**

**2 - Groundskeeper Shed**

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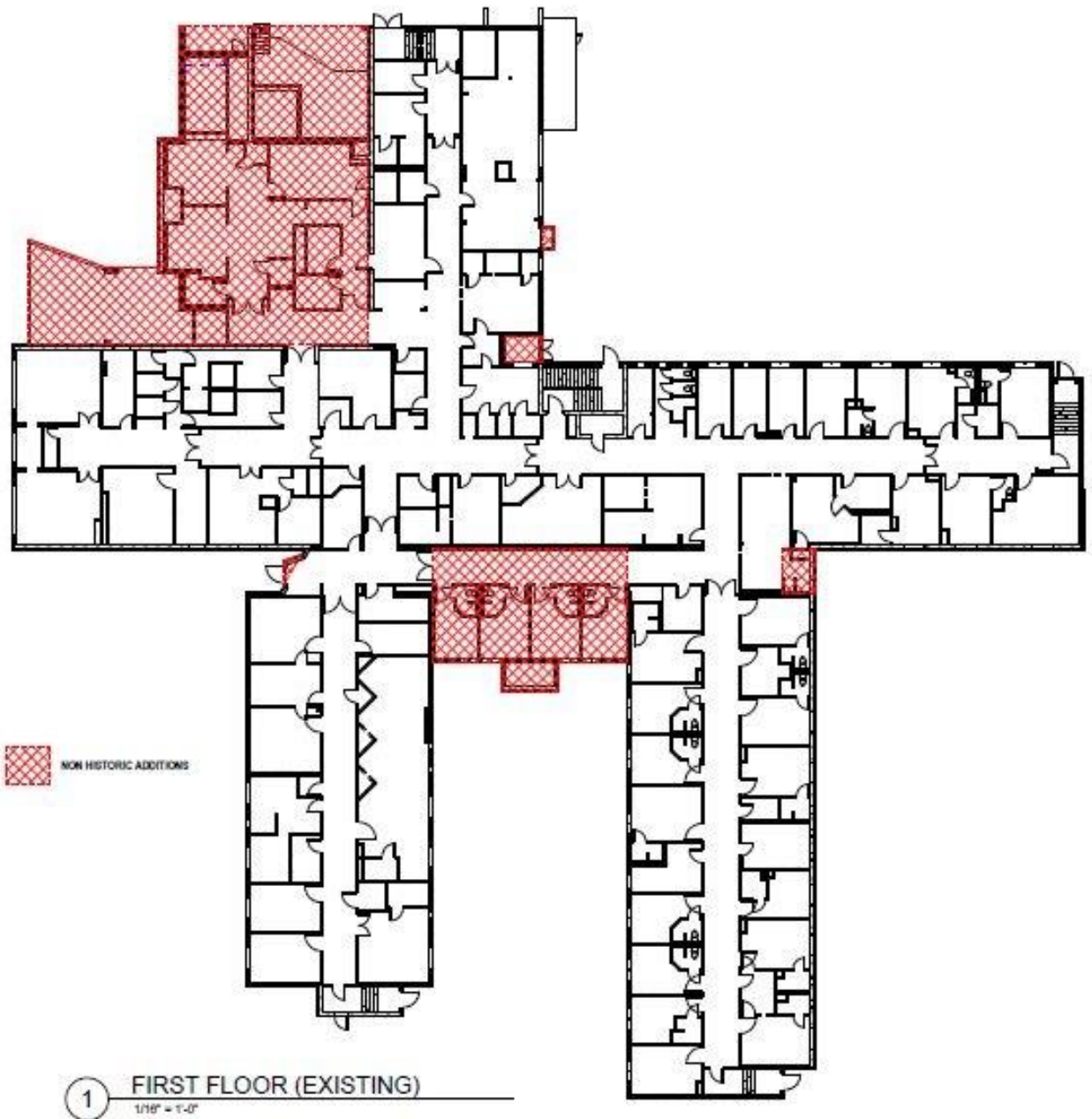
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## LIVINGSTON MEMORIAL HOSPITAL— KEY TO HOSPITAL WINGS and CORRIDORS



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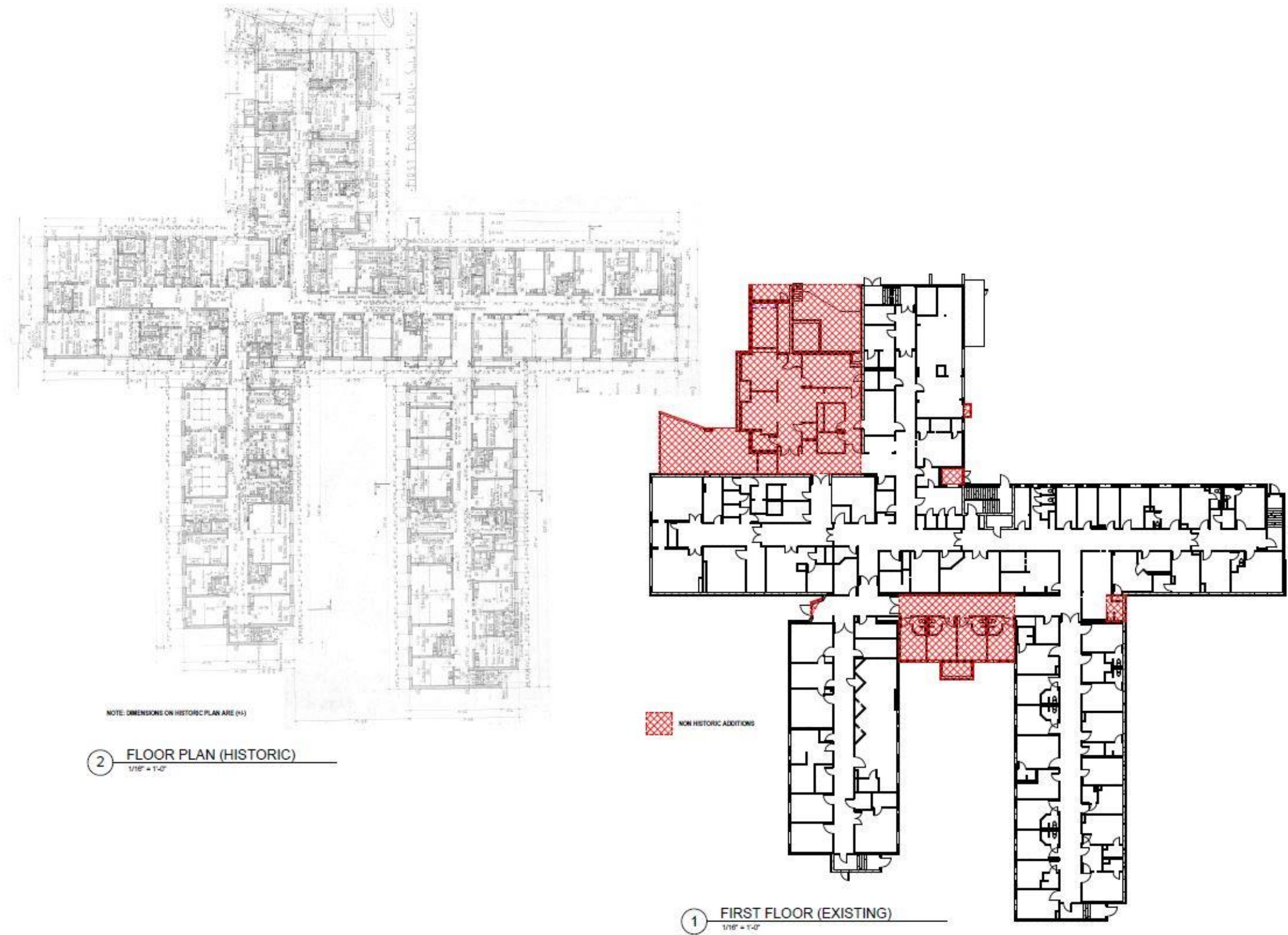
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## Historic Images



**Proposed Design, from the Livingston Enterprise, April 17, 1947**

Livingston Memorial Hospital

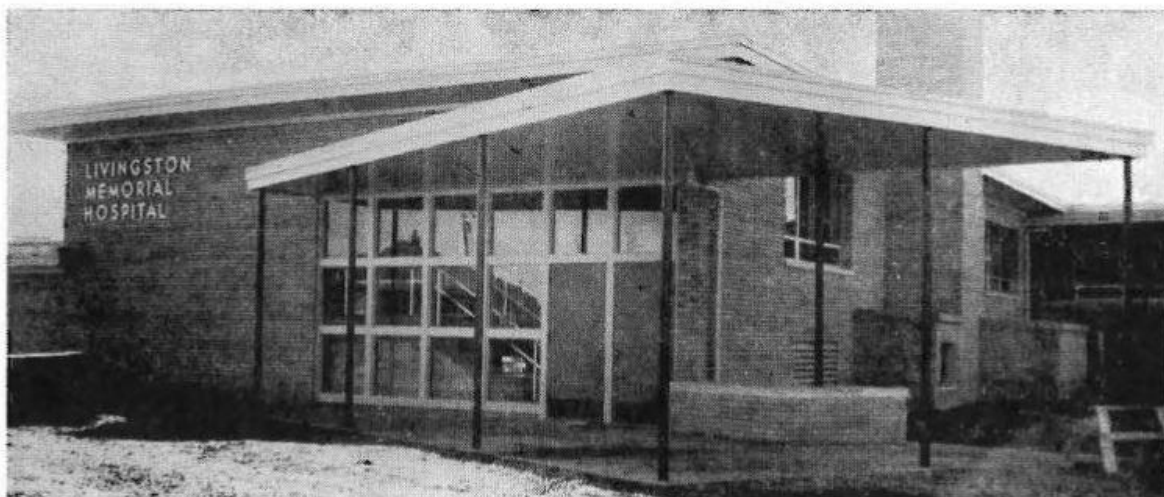
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Ground Breaking, from the Livingston Enterprise September 18, 1952



**LIVINGSTON**—The 52-bed Livingston Community Hospital was built at a cost of \$693,008.41 to replace the old Lott Hospital. Federal construction assistance in the amount of \$276,645.36 was approved September 4, 1952; the remainder of the construction cost was developed through local subscription.

Image from the Livingston Community Hospital Board of Health 1954 Biennial Report



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**Livingstone Memorial Hospital, circa mid-1950s.**

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**Aerial View, 1955**

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**Aerial View, 1973**

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## National Register Photographs

### Photolog

- Photo 01.** Original Main Entrance, NE Elevation of Administrative Wing, Aspect: SW  
**Photo 02.** SE Elevation of Administrative Wing – NE End, Aspect: NW  
**Photo 03.** SE Elevation of Administrative Wing, Aspect: N  
**Photo 04.** Junction of Hospital Core / Pediatric Wing (NE Elevation) and Administrative Wing (SE Elevation), Aspect: SW  
**Photo 05.** NW Elevation of Surgical Wing, Aspect: SE  
**Photo 06.** SW Elevation of Surgical Wing with Maternity Wing Hyphen (NW Elevation), Aspect: E  
**Photo 07.** NE Elevation of Pediatric Wing / Hospital Core, Aspect: W  
**Photo 08.** SE Elevation of Pediatric Wing (foreground), Aspect: NW  
**Photo 09.** SE and SW Elevation of Pediatric Wing (right) and SE Elevation of Nursing Wing, Aspect: N  
**Photo 10.** SE Elevation of Nursing Wing (left) and SW Elevation of Pediatric Wing, Aspect: NE  
**Photo 11.** NW Elevation of Maternity Wing, Aspect: S  
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**Photo 19.** NW Elevation of ER Addition, Aspect: SE  
**Photo 20.** Main Entrance, NW Elevation of ER Addition, Aspect: SE  
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**Photo 23.** South Lawn with Crabapple Tree and Cottonwood Trees, SE Elevation of Pediatric Wing and SE Elevation of Nursing Wing, Aspect: W  
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**Photo 25.** NW and SW Elevation of Mental Health Building and NW Elevation of Surgical Wing (background), Aspect: SE  
**Photo 26.** Primary Corridor, Pediatric Wing, Aspect: SE  
**Photo 27.** Primary Corridor, Pediatric Playroom, Aspect: N  
**Photo 28.** Primary Corridor, Pediatric Wing Entrance, Aspect: SW  
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**Photo 36.** Rooms Addition Corridor, Intersection with Nursing Corridor and Primary Corridor, Aspect: SE  
**Photo 37.** Primary Corridor, Intersection of Surgical Wing (foreground) and Hospital Core, Aspect: SE

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**Photo 38:** Primary Corridor, Hospital Core, Laundry Chute and Dumbwaiter, Aspect: NW

**Photo 39:** Primary Corridor, Intersection with Pediatric Corridor, Hospital Core and Nursing Wing, Aspect: SW

**Photo 40:** Primary Corridor, Intersection of Hospital Core (foreground) and Surgical Wing, Aspect: NW

**Photo 41:** Primary Corridor, Hospital Core (NE side), Typical Room to SE of Administrative Corridor, Aspect: NE

**Photo 42:** Primary Corridor, Surgical Wing, Aspect: NW

**Photo 43:** Primary Corridor, Surgical Wing, Scrub-In Area, Sub-Sterilization (right) and SW Operating Room, Aspect: N

**Photo 44:** Primary Corridor, Surgical Wing, SW Operating Room, Aspect: W

**Photo 45:** Primary Corridor, Surgical Wing, NE Operating Room, Aspect: E

**Photo 46:** Primary Corridor, Surgical Wing, Delivery Room, Aspect: S

**Photo 47:** Administrative Corridor, Original Fire Door from Main Entrance Foyer, Aspect: SE

**Photo 48:** Administrative Corridor, Main Entrance Foyer, Aspect: N

**Photo 49:** Administrative Corridor, Main Entrance Foyer, Aspect: SE

**Photo 50:** Administrative Corridor, Aspect: SW

**Photo 51:** Administrative Corridor, Laboratory (foreground) and Business Office, Aspect: NE

**Photo 52:** Administrative Corridor, Laboratory and Business Office (foreground), Aspect: SW

**Photo 53:** Administrative Corridor, Aspect: NE

**Photo 54:** ER Addition Corridor with Main Entrance, Aspect: NW

**Photo 55:** ER Addition Corridor, Hall to Primary Corridor, Aspect: SW

**Photo 56:** ER Addition, Main Entrance from Corridor, Aspect: SW

**Photo 57:** ER Addition, Aspect: NE

**Photo 58:** Rooms Addition from Nursing Corridor, Aspect: NW

**Photo 59:** Nursing Wing (right) from Rooms Addition Corridor, Aspect: NW

**Photo 60:** Rooms Addition Corridor, Patient Room, Aspect: W

**Photo 61:** Maternity Corridor, Aspect: SW

**Photo 62:** Maternity Corridor, Aspect: S

**Photo 63:** Maternity Corridor (SE side), Patient Room, Aspect: SE

**Photo 64:** Maternity Corridor (SE side), Converted 4-Room Ward, Aspect: W

**Photo 65:** Maternity Corridor Entrance, Aspect: SE

**Photo 66:** Maternity Corridor Entrance, Aspect: NW

**Photo 67:** Nursing Corridor, Aspect: NE

**Photo 68:** Nursing Corridor (NE side), Patient Room, Aspect: W

**Photo 69:** Nursing Corridor (SE side), Patient Room, Aspect: NW

**Photo 70:** Nursing Corridor, Patient Room, Aspect: S

**Photo 71:** Nursing Corridor Entrance, Aspect: SE

**Photo 72:** Basement, Main Corridor, Aspect: NE

**Photo 73:** Basement, Main Corridor, Aspect: SW

**Photo 74:** Basement, Administrative Wing, Secondary Corridor, Aspect: NE

**Photo 75:** Basement, ER Addition, Aspect: N

**Photo 76:** Basement, Administrative Wing, Office Space, Aspect: N

**Photo 77:** Basement, Administrative Wing, Boiler Room, Aspect: W

**Photo 78:** Basement, Primary Corridor (SW side), Cafeteria, Aspect: W

**Photo 79:** Basement, Primary Corridor (SW side), Cafeteria and Kitchen, Aspect: NW

**Photo 80:** Basement, Primary Corridor (SW side), Cafeteria Kitchen, Aspect: SW

**Photo 81:** Basement, Primary Corridor (SW side), Lounge, Aspect: SW

**Photo 82:** Basement, Primary Corridor (SW side), Laundry Room, Aspect: SW

**Photo 83:** Basement, Primary Corridor (SW side), Laundry Room, Aspect: W



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**Photo 01.** Original Main Entrance, NE Elevation of Administrative Wing, Aspect: SW

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**Photo 02.** SE Elevation of Administrative Wing – NE End, Aspect: NW

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**Photo 03.** SE Elevation of Administrative Wing, Aspect: N

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**Photo 04.** Junction of Hospital Core / Pediatric Wing (NE Elevation) and Administrative Wing (SE Elevation), Aspect: SW



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**Photo 05.** NW Elevation of Surgical Wing, Aspect: SE

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**Photo 06.** SW Elevation of Surgical Wing with Maternity Wing Hyphen (NW Elevation), Aspect: E

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**Photo 07.** NE Elevation of Pediatric Wing / Hospital Core, Aspect: W

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**Photo 08.** SE Elevation of Pediatric Wing (foreground), Aspect: NW



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**Photo 09.** SE and SW Elevation of Pediatric Wing (right) and SE Elevation of Nursing Wing, Aspect: N

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**Photo 10.** SE Elevation of Nursing Wing (left) and SW Elevation of Pediatric Wing, Aspect: NE

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**Photo 11.** NW Elevation of Maternity Wing, Aspect: S

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**Photo 12.** NW and SW Elevation of Maternity Wing, Aspect: E



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**Photo 13.** Rear Courtyard with Maternity Wing (left), Rooms Addition (center) and Nursing Wing, Aspect: NE

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**Photo 14.** SE Elevation of Maternity Wing (courtyard interior), Aspect: N



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**Photo 15.** SW Elevation of Rooms Addition (courtyard interior), Aspect: NE

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**Photo 16.** NW and SW Elevation of Nursing Wing, Aspect: E



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**Photo 17:** SW Elevation of Nursing Wing (foreground) and SW Elevation of Maternity Wing, Aspect: N

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**Photo 18:** NE Elevation of ER Addition, Aspect: SW

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**Photo 19:** NW Elevation of ER Addition, Aspect: SE

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**Photo 20:** Main Entrance, NW Elevation of ER Addition, Aspect: SE



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**Photo 21:** Groundskeeper Shed, Gravel Parking Lot and Cottonwood Trees, Aspect: SW

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**Photo 22:** Lawn with Crabapple Tree, SW Elevation of Pediatric Wing and SE Elevation of Nursing Wing, Aspect: NE

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**Photo 23:** South Lawn with Crabapple Tree and Cottonwood Trees, SE Elevation of Pediatric Wing and SE Elevation of Nursing Wing, Aspect: W



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**Photo 24:** Utility Building (Home Oxygen), NW and SW Elevation, Aspect: W



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**Photo 25:** NW and SW Elevation of Mental Health Building and NW Elevation of Surgical Wing (background), Aspect: SE

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**Photo 26:** Primary Corridor, Pediatric Wing, Aspect: SE

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**Photo 27:** Primary Corridor, Pediatric Playroom, Aspect: N

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**Photo 28:** Primary Corridor, Pediatric Wing Entrance, Aspect: SW

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**Photo 29:** Primary Corridor, Pediatric Wing, Aspect: NW



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**Photo 30:** Primary Corridor, Intersection of Pediatric Wing, Hospital Core and Nursing Wing, Aspect: SE

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**Photo 31:** Primary Corridor, Pediatric Wing (SW side), Patient Room, Aspect: SW

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**Photo 32:** Primary Corridor, Hospital Core, Aspect: NE



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**Photo 33:** Primary Corridor, Hospital Core, Janitor's Closet and Restrooms (left) and Split-Level Entrance (right), Aspect: E

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**Photo 34:** Primary Corridor, Hospital Core, Split-Level Entrance, Aspect: NE

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**Photo 35:** Primary Corridor, Intersection of Hospital Core with Administrative Wing (left), Aspect: SE

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**Photo 36:** Rooms Addition Corridor, Intersection with Nursing Corridor and Primary Corridor, Aspect: SE

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**Photo 37:** Primary Corridor, Intersection of Surgical Wing (foreground) and Hospital Core, Aspect: SE



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**Photo 38:** Primary Corridor, Hospital Core, Laundry Chute and Dumbwaiter, Aspect: NW

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**Photo 39:** Primary Corridor, Intersection with Pediatric Corridor, Hospital Core and Nursing Wing,  
Aspect: SW



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**Photo 40:** Primary Corridor, Intersection of Hospital Core (foreground) and Surgical Wing, Aspect: NW

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**Photo 41:** Primary Corridor, Hospital Core (NE side), Typical Room to SE of Administrative Corridor, Aspect: NE

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**Photo 42:** Primary Corridor, Surgical Wing, Aspect: NW

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**Photo 43:** Primary Corridor, Surgical Wing, Scrub-In Area, Sub-Sterilization (right) and SW Operating Room, Aspect: N

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**Photo 44:** Primary Corridor, Surgical Wing, SW Operating Room, Aspect: W

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**Photo 45:** Primary Corridor, Surgical Wing, NE Operating Room, Aspect: E

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**Photo 46:** Primary Corridor, Surgical Wing, Delivery Room, Aspect: S



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**Photo 47:** Administrative Corridor, Original Fire Door from Main Entrance Foyer, Aspect: SE

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**Photo 48:** Administrative Corridor, Main Entrance Foyer, Aspect: N

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**Photo 49:** Administrative Corridor, Main Entrance Foyer, Aspect: SE

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**Photo 50:** Administrative Corridor, Aspect: SW

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**Photo 51:** Administrative Corridor, Laboratory (foreground) and Business Office, Aspect: NE



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**Photo 52:** Administrative Corridor, Laboratory and Business Office (foreground), Aspect: SW



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**Photo 53:** Administrative Corridor, Aspect: NE

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**Photo 54:** ER Addition Corridor with Main Entrance, Aspect: NW

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**Photo 55:** ER Addition Corridor, Hall to Primary Corridor, Aspect: SW

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**Photo 56:** ER Addition, Main Entrance from Corridor, Aspect: SW

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**Photo 57:** ER Addition, Aspect: NE

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**Photo 58:** Rooms Addition from Nursing Corridor, Aspect: NW



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**Photo 59:** Nursing Wing (right) from Rooms Addition Corridor, Aspect: NW

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**Photo 60:** Rooms Addition Corridor, Patient Room, Aspect: W

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**Photo 61:** Maternity Corridor, Aspect: SW

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**Photo 62:** Maternity Corridor, Aspect: S

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**Photo 63:** Maternity Corridor (SE side), Patient Room, Aspect: SE



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**Photo 64:** Maternity Corridor (SE side), Converted 4-Room Ward, Aspect: W



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**Photo 65:** Maternity Corridor Entrance, Aspect: SE

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**Photo 66:** Maternity Corridor Entrance, Aspect: NW

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County and State



**Photo 67:** Nursing Corridor, Aspect: NE

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**Photo 68:** Nursing Corridor (NE side), Patient Room, Aspect: W

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**Photo 69:** Nursing Corridor (SE side), Patent Room, Aspect: NW

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**Photo 70:** Nursing Corridor, Patient Room, Aspect: S



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**Photo 71:** Nursing Corridor Entrance, Aspect: SE

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**Photo 72:** Basement, Main Corridor, Aspect: NE

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**Photo 73:** Basement, Main Corridor, Aspect: SW

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**Photo 74:** Basement, Administrative Wing, Secondary Corridor, Aspect: NE

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**Photo 75:** Basement, ER Addition, Aspect: N

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**Photo 76:** Basement, Administrative Wing, Office Space, Aspect: N



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**Photo 77:** Basement, Administrative Wing, Boiler Room, Aspect: W

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**Photo 78:** Basement, Primary Corridor (SW side), Cafeteria, Aspect: W

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**Photo 79:** Basement, Primary Corridor (SW side), Cafeteria and Kitchen, Aspect: NW

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**Photo 80:** Basement, Primary Corridor (SW side), Cafeteria Kitchen, Aspect: SW

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**Photo 81:** Basement, Primary Corridor (SW side), Lounge, Aspect: SW



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**Photo 82:** Basement, Primary Corridor (SW side), Laundry Room, Aspect: SW



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**Photo 83:** Basement, Primary Corridor (SW side), Laundry Room, Aspect: W